STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS A Standard Recertification Survey was conducted on 02/05/07 to 02/08/07 at Family Care Certified Services. Twenty one (21) Clinical Records were reviewed and are identified as Patients #1 to #21. Nine (9) Home Visits were made to Patients #2, #3, #6, #7, #12, #13, #14, #19 and #21. Fifteen (15) Personnel Records were reviewed and are identified as Employees #1 to #15.	G 000		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE. The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on review of the clinical records, the agency's policy and procedure and staff interview, the agency's nursing staff failed to ensure that the paraprofessional staff perform all the ordered patient care tasks according to the Plan of Care in six (6) of twelve (12) patients receiving paraprofessional services (Patients #2, #4, #7, #9, #10 & #21). The agency's failure to ensure that the paraprofessional staff provides the ordered patient care tasks according to the Plan of Care places all patients at risk for poor quality of care and unmet patient care needs. Findings are:	G 225	A meeting was held with Administrator, Director of Nursing, Director of Long Term Program, PI Committee, and the HHA Coordinator to review, assess, design, and implement a plan of action. The CHHA will reinforce with Nursing department and ensure that revised HHA Care Plans are written each recertification period. The LTHHCP will review/rewrite their HHA Care Plans every six months. The Director of Nursing will reinforce procedure that copies of revised HHA Care Plans are distributed appropriately within the patients home, the medical record, and the HHA Coordinator (who in turn will forward a copy to the aide agency).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 1 Patient #2 was admitted to the agency on 06/27/06 with diagnoses including Varicose Vein Lower Extremities with Ulcer, Venous Insufficiency, Hypertension and Diabetes Mellitus. Review of the Plans of Care dated 10/22/06 - 12/23/06 and 12/24/06 - 02/21/07 ordered home health aide (hha) service three (3) - five (5) days x two (2) - four (4) hours to provide personal care for ADL (Activities of Daily Living), assist for meal preparation, for light housekeeping and for HEP (Home Exercise Program). Review of the aide duty sheets from 11/27/06 - 01/19/07 consistently failed to document that the hha provided the patient with assistance with the HEP as ordered on the Plan of Care and directed on the Home Health Aide/Personal Care Aide Care Plan dated 06/27/06. During interview with the Nursing Supervisor, Director of Patient Services (DPS) and Quality Assurance Nurse on 02/08/07 at 10:00 AM, the staff acknowledged the findings. Patient #21 was admitted to the agency on 01/17/00 with diagnoses including Cerebral Vascular Disease and Hypertension. Review of the Plans of Care dated 10/18/06 - 12/16/06 and 12/17/06 - 02/14/07 ordered PCA (Personal Care Aide) service seven (7) hours x six (6) days to assist with change bed linen, light housekeeping and assist with ambulation. Review of the aide duty sheets lacked documentation that the PCA assisted the patient with ambulation on 12/04 - 12/08, 12/11 - 12/15,	G 225	The Administrator will compose a letter requesting meetings with representatives of all HHA agencies. Letters will be sent by March 9, 2007 requesting meeting dates for the week of March 19th . During the meeting, the administrator will review the language in contract detailing the responsibility of the Aide Agency to check the accuracy of the documentation submitted. Discussion to also include communication from the Aide to the Nurse as to when they have questions as to the assigned tasks given. The HHA Coordinator, and the LT Office Coordinator will continue to review accuracy of completion of the duty sheet. As part of the Aide supervision sheet, a new prompt will be added, requesting the Nurse to also include "documentation instruction" as part of the aide supervisory visit. The Directors of Nursing for both programs will instruct the Nurses of this addition to the aide supervisory form. When deemed necessary, the Nurse will also instruct the aide on proper completion of the paperwork, by having the aide complete the duty sheet in the presence of the Nurse.	

FAMILY CARE CERTIFIED SERVICES
NURSING VISIT REPORT

HCC_____
CHN_____

NAME:_____ DATE OF VISIT:_____ AR#_____

VITAL SIGNS:

BLOOD PRESSURE (R)____ (L)____
LYING:
SITTING:
STANDING:

TEMP (O) (R) (A):_____
AP
RP
RHYTHM
RESP
LUNGS: (R)____ (L)____

SKIN/WOUND:
SITE:_____
DRAINAGE:_____
WCAP: Y ☐ N ☐

EDEMA:
SITE:_____
WEIGHT:_____
DESCRIPTION:
Pitting() Non-Pitting()

DIAGNOSIS:_____ LAST M.D. VS:_____ NEXT MD VS:_____ MD NAME:_____

CARDIOVASCULAR

Pallor	()	Periph Circ	()
SOB	()	Homans Signs	()
DOE	()	Phlebitis	()
Palp	()	Diaphoresis	()
Orthopnea	()	Vomiting	()
Bradycardia	()	Nausea	()
Tachycardia	()	Anxiety	()
Cyanosis	()	Pacemaker	()

URINARY

Odor	()	Hematuria	()
Burning	()	Concentration	()
Discharge	()	Distention	()
Frequency	()	Incontinence	()
Color	()	Catheter	()
Nocturia	()	Irrigation	()
		Foley Size	_____

NUTRITION: DIET:_____
INSTRUCTIONS:_____

RESPIRATORY

SOB	()	Cough	()	Sputum	()
Anxiety	()	Prod	()	Color	()
Non-Prod	()	Hemoptysis	()		

G.I.

Vomiting	()	Bleeding	()
Appetite	()	Bowel Habits	()
Nausea	()	Incontinence	()
Distention	()	Diarrhea	()
		Flatus	()

DIABETIC

Insulin	()	Neuropathy	()
Site Rotation	()	Skin Care	()
Urine Test	()	Foot Care	()
BS Test	()	Vision	()
S&S Hyperglycemia	()	S&S Hypoglycemia	()

FALL PREVENTION Transfer Demo ☐
Safe ☐ Unsafe ☐
Instruct ☐ Reinforce ☐

MUSCULO-SKELETAL

Mobility	()	Paresthesia	()
Ambulation	()	ROM	()
Weakness	()	Amputee	()
Deformities	()	Cast Care	()
Bleeding	()	Treatments	()
		Weight Bearing	()

NEURO

Headache	()	Vomiting	()
Weakness	()	Gait	()
Affect	()	Syncope	()
Orientation	()	Vertigo	()
Consciousness	()	Hemiparesis	()
Dizziness	()	Speech	()
Nausea	()	Seizures	()

MEDICATIONS:
Compliance () Changes ()
Instruction:_____

NARRATIVE/TEACHING

Pain/Site:_____ Relieved By:_____
Scale: 0 1 2 3 4 5 6 7 8 9 10

All instruction with V.U./R.D by Patient/S.O.: ☐ Y ☐ N Pink Note Attached: ☐ Y ☐ N Patient/Family involved in POC changes ☐

HHA: DAYS:____ HOURS:____ PERSONAL CARE:____ HOUSEKEEPING:____ ADL:____ ORIENTATION:____ SUPERVISION:____

HHA / INSTRUCTIONS **DOCUMENTATION REVIEWED:**_____

PLAN: Describe plan for follow-up. What should be done on the next visit? Include any modifications in the Care Plan.

Signature of Nurse:_____ Title:_____
Next Nursing Visit:_____ Frequency:_____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 2 12/18 - 12/23, 12/26/06 - 01/05/07, 01/08 - 01/12 and 01/15 - 01/19/07 as directed on the Home Health Aide/Personal Care Aide Care Plans dated 01/17/06 and 01/11/07. Review of the aide duty sheets from 12/04/06 - 01/19/07 consistently lacked any documentation of the provision of personal care (shower, sponge bath, hair grooming, dressing or skin care) on Tuesdays and Thursdays as directed on the Home Health Aide/Personal Care Aide Care Plan dated 01/17/06 and 01/11/07. During interview with the Nursing Supervisor on 02/08/07 at 11:00 AM, the Supervisor acknowledged the findings. Patient # 7 was admitted to the agency on 12/16/05 with the diagnoses including Insulin Dependent Diabetes and Benign Essential Hypertension. The Plan of Care dated 11/14/06 - 01/12/07 ordered PCA service three (3) days, four (4) hours per day for nine (9) weeks to assist the patient with ADLs, personal care, meal preparation, change bed linen and light housekeeping. Review of the aide duty sheets from 12/11/06 - 12/26/06 lacked documentation that the PCA had assisted the patient with ambulation using the walker, assisted the patient with toileting, reminded the patient to take medications and assisted the patient with mouth care according to the Plan of Care and as directed on the Home Health Aide/Personal Care Aide Care Plan dated 12/16/06.	G 225	The Performance Improvement department will be responsible to monitor the accuracy of completion of the duty sheets. Each quarter, as part of their chart audit in preparation of the PAC meeting, the PI Nurses will review 10 charts for accuracy of completion of the duty sheets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 3 During survey the agency was requested to provide aide duty sheets for January 2007. The agency did not provide any additional aide duty sheets as requested. Patient #4 was admitted to the agency on 03/24/06 with diagnoses including Congestive Heart Failure, Ischemic Heart Disease, and Hypertension. Review of the Plan of Care dated 01/11/07 - 03/11/07 ordered combination of hha/PCA service seven (7) days a week x six (6) to eight (8) hours a day for personal care, assistance with ADL, meal preparation and etc. Review of the aide duty sheets lacked documentation that the paraprofessional assisted the patient with ambulation, assisted the patient with HEP and feeding on 01/11, 01/13, and 01/15 - 01/19/07. Further review of the aide duty sheets lacked documentation that the paraprofessional assisted the patient with transfer, turning and positioning, elevation/positioning of extremities and maintained standard precautions as directed on the Home Health Aide/Personal Care Aide Care Plan dated 12/05/06. During interview with the Director of Patient Services (DPS) on 02/08/07 at 10:30 AM, the DPS acknowledged the survey findings. Patient #9 was admitted to the agency on 11/20/00 with diagnoses including Neoplasm of the Genitourinary Organs, Total Abdominal Hysterectomy, Coronary Heart Disease, and Hypertension. Review of the Plans of Care dated 10/20/06 -	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 4 12/18/06 and 12/19/06 - 02/16/07 ordered PCA service seven (7) days a week x five (5) hours a day for personal care, for assistance with ADL, meal preparation and etc. Review of the aide duty sheets from 12/02/06 - 01/05/07 lacked documentation that the PCA assisted the patient with mouth care, and ambulation as directed on the Home Health Aide/Personal Care Aide Care Plan dated 09/06. Review of the aide duty sheets documented that the PCA assisted the patient with feeding on 12/3, 12/8 - 12/9 - 12/23, 12/31/06 and 01/5 - 01/19/07. This task was not an assigned task on the Home Health Aide/Personal Care Aide Care Plan dated 09/06. During interview with the Director of Patient Services (DPS) on 02/08/07 at 10:30 AM, the DPS acknowledged the survey findings. Patient #10 was admitted to the agency on 04/10/06 with diagnoses of Cerebrovascular Disease, Diabetes Mellitus, Hypertension and Atherosclerosis. Review of the Plans of Care dated 10/07/06 - 12/05/06 and 12/06/06 - 02/03/07 ordered PCA service seven (7) days a week x eight (8) hours a day to provide personal care, for assistance with ADL and etc. Review of the aide duty sheets from 11/27/06 - 01/08/07 lacked documentation that the PCA assisted the patient with mouth care on 11/27 - 12/1, 12/4 - 12/8, 12/11, 12/14, 12/15, and 12/18 - 12/22/06. Further review of the aide duty sheets lacked documentation that the PCA reminded the	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 5 patient to take the medications on 01/08 - 01/11/07 as directed on the Home Health Aide/Personal Care Aide Care Plan dated 12/30/06. During interview with the Director of Patient Services (DPS) on 02/08/07 at 10:00 AM, the DPS acknowledged the survey findings. Review of the agency's policy and procedure "Home Health Aide/Personal Care Aide" under the section identified as "Procedure" noted the following: 4. "The aide will be instructed on the patient plan of care according to the aide care plan based on patient's needs assessed by the nurse and patient's agreement." 5. "The aide care plan will include the care to be rendered, patient limitations, precautions and changes in patient condition that warrants agency notification. Care plan will be revised according to patient status and needs." 6. "The aide will document the tasks performed for the patient on the aide duty sheet. This will reflect the aide care plan." During interview with the Administrator and the DPS on 02/07/07 at 2:10 PM, the DPS agreed with the survey findings. The DPS stated that the aide duty sheets are only spot checked by the nursing coordinators. The Administrator further stated that the vendor agencies are responsible to review the aide duty sheets. The agency staff could not provide an explanation for the paraprofessional staff's failure to perform	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337237	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES NASSAU CHHA	120 WEST JOHN STREET HICKSVILLE, NY 11801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 225	Continued From page 6 the ordered patient care tasks according to the Plan of Care and the failure to document on the aide duty sheets according to the agency's policy and procedure.	G 225		

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0204L001	A. BUILDING _____ B. WING _____	07/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY SERVICE SOCIETY OF YONKERS	70 ASHBURTON AVE FL 6 YONKERS, NY 10701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full survey was conducted on 7/12 & 13/07. A total of six (6) clinical records were reviewed (#1 through #6). A total of seven (7) personnel records were reviewed (#1 through #7).	H 000	**H 512 Medical Orders** The agency has conducted a 100% patient record audit to identify the last nursing review and request for medical orders for each patient. The agency has documented the date of the next required medical orders review and request for each client in an electronic monitoring system. ***Completely implemented on 9/6/07.***	
H 512	766.4(c) Medical Orders 766.4 Medical orders. (c) Such orders shall be reviewed and revised as the needs of the patient dictate but no less frequently than every six months, except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid patient This RULE is not met as evidenced by: Based on clinical record review, and staff interview, the agency failed to ensure that the MD orders were reviewed and revised no less frequently than every six (6) months in three (3) out of six (6) records reviewed (# 1, #2, #6). Findings include: Patient # 1 was admitted to the agency on 1/25/06 with the diagnosis of Parkinson's Disease. Initial orders were dated 1/25/06. MD orders were not revised until 3/16/07. Patient #2 was admitted to the agency on 4/18/05 with the diagnoses of Arthritis and Blindness. The Initial MD order was dated 5/4/05. MD	H 512	***Periodic Reviews*** The Nurse Manager conducts weekly reviews of all clients' medical orders required for review in the succeeding month. The Nurse Manager conducts medical orders reviews and makes appropriate and timely requests for medical orders for each client. The Nurse Manager reviews medical orders for each patient upon receipt. ***Ongoing Monitoring*** When medical orders are received for services that the agency is to provide to each patient the next date for review and request for medical orders will be entered into the agency's electronic tracking system by the Nurse Manager. Upon review of each medical order, if the agency needs additional medical orders or medical orders need to be clarified, then such orders will be requested by mail, by FAX or by telephone; properly recorded and authenticated by the Nurse Manager. If any patient's medical orders are not received within 5 days preceding the day of required receipt by the agency; then the Nurse Manager will contact	

STATE FORM
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Amended

YS Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0204L001	A. BUILDING _____ B. WING _____	07/13/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMILY SERVICE SOCIETY OF YONKERS	70 ASHBURTON AVE FL 6 YONKERS, NY 10701

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 512	Continued From Page 1 orders were not revised until 2/12/07. Patient # 1 was admitted to the agency on 1/29/05 with the diagnosis of a Hip Fracture. Initial orders were dated 2/25/05. MD orders were not revised until 8/8/06. On interview of 7/19/07, the Administrator stated that the reason the Medical Orders were signed late was because the agency had a personnel problem in relation to nursing staff. The failure to ensure that MD orders are reviewed and revised no less frequently than every six (6) months has the potential for patients to receive incorrect care and/or treatment that is not in accordance with the physician's wishes.	H 512	the medical practitioner's office by telephone, and FAX the required orders to the medical practitioner's office for immediate review and signature. The Nurse Manager will ensure that follow up contacts are conducted until all appropriate medical orders are received by the agency on a timely basis as required by medical orders regulations. Patients # 1, 2, and 6 have current, timely and appropriate medical orders at this time. ***Completed by 9/6/07.*** ***<u>Ongoing Monitoring</u>*** ***The DPS will orient the QIC record reviewers to the requirements for medical orders and the agency plan of correction. The QIC record reviewers will report compliance with the plan of correction and findings of above referenced reviews to the PI Committee and governing authority on a quarterly basis.*** ***This plan of correction was instituted on 9/6/07.*** The Director of Patient Services will be responsible to ensure that this plan of correction is instituted and remains in effect.	
H 722	766.6(a)(10) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (10) a discharge summary when the patient is discharged from the agency including: (i) documentation of discharge planning preparation; (ii) notification to the patient's authorized practitioner; (iii) reasons for discharge and date of discharge; (iv) summary of care given and patient's progress;	H 722		

Amended

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0204L001	A. BUILDING _____ B. WING _____	07/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY SERVICE SOCIETY OF YONKERS	70 ASHBURTON AVE FL 6 YONKERS, NY 10701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 722	Continued From Page 2 (v) patient status upon discharge including a description of any remaining needs for patient care and supportive services; (vi) patient or family ability to self-manage in relation to any remaining problems; and (vii) recommendations and referral for any follow-up care, if needed. This RULE is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to notify the patient's authorized practioner when the patient was discharged from the agency in three (3) of three (3) discharged charts reviewed (#1, 2, #3). On interview of 7/13/07 the Director of Patient Services (DPS) stated that she was not aware that the patient's MD had to be notified when a patient was discharged. Failure of the agency to notify the MD of a patient's discharge has the potential for patients discharge needs to be unmet.	H 722	**H722 Patient Care Record** The agency's policy and procedure requires that notification of impending patient discharge is provided to the patient and the medical practitioner(s) and documented by the Nurse Manager at least 48 hours preceding the patient's discharge from the agency. This section of the discharge planning records was not completed in the 3 records reviewed. The current Director of Patient Services was aware of MD's notification requirement prior to survey; Nurse Manager was educated regarding this requirement on July 16, 2007. ***This education was completed on 7/16/07.*** ***The Director of Patient Services will assure the consistent implementation of this practice by monitoring the discharge record of all patients through 9/30/07.*** ***<u>Ongoing Monitoring</u>*** ***The QIC record review sample includes review of discharged clients. This review will include at least 3 recently discharged patient records. The QIC will review the discharge records for documentation of discharge notification and report to the governing authority on a quarterly basis.***	
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and	H1142		

Amended

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0204L001	A. BUILDING _____ B. WING _____	07/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY SERVICE SOCIETY OF YONKERS	70 ASHBURTON AVE FL 6 YONKERS, NY 10701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 3 alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This RULE is not met as evidenced by: Based on review of the agency's policy and procedure manual and interview, the agency failed to comply with the NYCRR related to Health Provider Network (HPN). Findings include: On review of the agency's Policy/Procedure manual, the agency failed to have a policy developed related to the HPN.	H1142	**H 1142 Governing Authority** The governing authority has developed and adopted a policy and procedure regarding implementation of a sufficient number of HPN coordinators and users, adherence to the contracts and agreements for HPN use and requirements for current and timely updates to the agency communication directory to insure receipt and action regarding alerts and requests for information. The Governing Authority has adopted these policies and procedures on this date. The Director of Patient Services will be responsible to insure implementation of the HPN policies and procedures. Attached please find the agency policies and procedures for review.	

Amended

S Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0204L001	A. BUILDING _____ B. WING _____	07/13/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILY SERVICE SOCIETY OF YONKERS	70 ASHBURTON AVE FL 6 YONKERS, NY 10701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 4 During an interview with the Administrator on 7/16/07, the administrator stated that the agency did not have an HPN policy. Failure to have an HPN Policy has the potential for the agency not having appropriate guidelines for staff to follow relative to the use of the HPN.	H1142	**H1338 Personnel** The agency developed a form to document validation of the paraprofessional training certificates preceding this survey. ***The upper portion of the attached form is completed by FSSY Administrative Home Care Coordinator (AHCC). The AHCC transmits the training certificate along with the Certificate Verification form to the training site by FAX for review and validation prior to orientation of prospective employees. The administering agency confirms/denies validation of the training certificate on the lower portion of the agency form, attached for your review.*** ***This plan of correction is completed on 9/6/07.*** ***Further, the agency requires competency testing of all paraprofessionals upon application to validate that applicants have required personal care aide or home health competencies before offers of employment are made. Each new employee personnel file will be reviewed for required training validation by the Administrative Director of Home Care (ADHC) before assignment.*** ***This plan of correction is completed on 9/6/07.*** The AHCC will validate all presently employed paraprofessional staff training certificates by using this process within 3 months.	
H1338	766.11(g) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (g) that personnel records include verifications of employment history and qualifications for the duties assigned and, as appropriate, signed and dated applications for employment; records of professional licenses and registrations; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessment shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given patient medical records under section 766.6 of this Part. This RULE is not met as evidenced by: Based on personnel record review and staff interview, the agency failed to verify qualifications for three (3) out of four (4) personal care/home health aides (PCA/HHA) prior to hiring (# 2, 3, #4). On interview of 6/16/07 the Assistant Director of	H1338		

Amended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0204L001	A. BUILDING _____ B. WING _____	07/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY SERVICE SOCIETY OF YONKERS	70 ASHBURTON AVE FL 6 YONKERS, NY 10701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1338	Continued From Page 5 Home Care Services (ADHCS) stated that the agency was not always verifying the aide credentials s but that they now have a form that is utilized to do this. Failure to verify PCA/HHA credentials has the potential for unqualified staff providing services to the agency's patients.	H1338	The AHCC is responsible for implementation of this plan of correction. Completion of validation of all training certificates will be completed by November 1, 2007. ***Ongoing Monitoring*** ***An electronic monitoring feature was added to the audit process for paraprofessional staff. This feature will generate a report indicating receipt of validation of certificates for all personal care and home health aides. Notification reports are generated and reviewed by ADHC on a weekly basis.*** ***A 50 % sample of new employee files will be reviewed by QCI record reviewers through June 2008 and will be reported to the PI Committee and governing authority. Each employee file will be monitored for all regulatory requirements each year, preceding annual evaluation, by the ADHC and AHCC. Findings will be reported to the DPS of any paraprofessional in need of requirements before the annual evaluation. The DPS and ADHC will be responsible to assure that all such requirements are fulfilled before ongoing assignment.*** The Admin. Dir. of Home Care will ensure this Plan of Correction is consistently implemented.	

Amended

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full Survey was conducted on 07/17/07 at Caring Hands Home Care, Inc. One (1) patient record was reviewed and is identified as Patient #1. Seven (7) personnel files were reviewed and are identified as Employees #1 through #7.	H 000		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Rule is not met as evidenced by: Based on patient record review and interview with the Owner, the agency failed to ensure that the medical orders were signed within 30 days in one (1) of one (1) records reviewed (Patients #1). The agency's failure to ensure that the orders are signed within 30 days places the patients at risk for unsafe and poor quality care. Findings are:	H 514	see pg. 2 Amended X1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margit Durken — TITLE: Owner — (X6) DATE: 9/19/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From Page 1 Patient #1 was admitted to the agency on 04/28/06 with diagnoses including Acute Encephalomyelitis, Tracheostomy, and Quadriplegia. Review of medical orders dated 01/25, 01/26, 01/27 and 01/31/07 lacked physician's signature within thirty (30) days. During an interview with the Owner on 07/17/07 at 12:00 Noon, the Owner acknowledged the findings. REPEAT DEFICIENCY FROM 05/17/2006 SURVEY	H 514	**H 514** **A) The Director of Nursing will conduct an in-service training on medical order transcription with both the medical and nursing staff in 10/03/07 according to the agency's medication / transcription policy and procedure. Authorized practitioner must sign orders within 30 days. Inservice to include clinical nursing supervisor, current primary day nurses and Home visit MD. (Dr.Spears) And or other primary physicians on other cases.** **B) To prevent the re-occurrence of this issue all charts will be audited monthly starting 10/04/07 until 100% compliance is obtained x 2; following, quarterly audits will be performed to ensure compliance.** **C) The quality improvement staff will develop a medical order transcription audit tool based on the agency's policy and procedure in 10/04/07. Staff will perform audit based on an established calendar. All charts will be included in the audit for one year. The Director of Nursing will in-service all staff regarding the agency's medical orders transcription policy and the audit that will be conducted in 10/04/07.** **D) Following chart audit a written report will be generated by the quality improvement staff; findings will be presented for discussed during the quarterly Quality Improvement Committee meeting. Ongoing in-services to continue.**	10/5/07
H 602	766.5(a) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (a) sufficient numbers of appropriately trained and oriented supervisory staff are available to ensure the quality of patient care services provided by the agency. Such supervision shall include: (1) ongoing review of cases and delegation of assignments by appropriate health care professionals; (2) in-home visits to direct, demonstrate and evaluate the delivery of patient care; (3) provision of clinical consultation; and (4) professional consultation on agency policies and procedures. This Rule is not met as evidenced by:	H 602		

Amended x1

Bright Duncan (Counsel) 9/19/07

SR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 602	Continued From Page 2 Based on patient record review and staff interview, the agency failed to ensure that the nursing staff were supervised and evaluated during the delivery of patient care in one (1) of one (1) patients reviewed. (Patient #1) The agency's failure to supervise and evaluate the provision of skilled nursing services places the patient at risk for poor quality care. Findings are: Patient #1 was admitted to the agency on 04/28/06 with diagnoses including Acute Encephalomyelitis, Tracheostomy and Quadriplegia. The Plan of Care from the start of care to 10/28/07 ordered Skilled Nursing (SN) twenty four (24) hours x seven (7) days for this ventilator dependent patient. Record review lacked documentation of in-home supervision of the provision of patient care. The record lacked documentation of on-going communication with the nurses providing patient care. During an interview with the Owner on 07/17/07 at 12:00 Noon, the Owner stated the nurses are to be supervised at least annually and acknowledged that there was no documented supervision of the nurses providing care to this patient. REFER TO PERSONNEL 766.11 (k)	H 602		
H 712	766.6(a)(5) Patient care record 766.6 Patient care record.	H 712	see addendum	9/19/07 SR

Bright Durkin Owner 8/15/07

Pg. #3,4
H712

Completion Date
September 19th, 2007

766.6(a) (5) Patient Care Record

A) Corrective Actions:
The Director of Nursing shall be the responsible designee to ensure the plan of corrections of the Patient Care Record.
Current Physician Therapist (NS) has been consulted regarding therapy notes. New therapy notes are being changed and revised

- 1.See new notes/ still being revised/ Physical Therapist currently being counseled on therapeutic patient notes

B) Identifying potential for Reoccurrence of Deficiency Cited:
All therapists are to use a new therapy form. Therapist Job description to also include identifying data in notes, random therapy notes to be reviewed at QA meeting every four months. Q3mo

C) Systematic Changes:
New Quality Assurance committee to include one therapist. New QA therapist.

-Denise Reigel Cappaccio – Speech Therapist (see resume)(currently being faxed, she's on vacation)

D) Monitoring System:
Director of Nursing every two-week review of therapy notes to include more specific notes.
New QA Committee to review random notes every four months. 3mo

- 2.See adjusted QA agenda
- 3.See adjusted Physical Therapist Notes
- 4.See adjusted Chart Review Form

SR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 712	Continued From Page 4 treatments with no specific information for each visit. During an interview with the Owner on 07/17/07 at 11:55 AM, the Owner stated "I know they are not good".	H 712		
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on patient record review, policy and procedure review, personnel record review and interview with the Owner, the Governing Authority (GA) failed to ensure compliance with all applicable Federal, State, and local statutes, rules and regulations as evidenced by the following deficiencies which are a repeat deficiencies from the survey of 05/17/06. The GA's failure to ensure compliance with all rules and regulations, and to ensure the provision of responsible operation and management of the home care agency places all patients at risk for poor quality of care. This was evident in the following deficiencies: 766.4 Medical Orders	H1002	see addendum Unaccepted 8/28/07 SR The agency's plan of correction does not address the Governing Authority's role in assuring that the agency implements their POC so the repeat deficiency does not occur.	9/19/07
		—	see addendum	9/19/07

Bright Dwelling Owner 8/15/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 5 766.5 Clinical Supervision 766.6 Patient Care Record 766.11 Personnel 766.12 Records and Reports	H1002		
H1008	766.9(d) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (d) adopt and approve amendments to written policies regarding the management and operation of the home care services agency and the provision of health care services. This Rule is not met as evidenced by: Based on review of the agency's policy and procedure manual and staff interview, the Governing Authority (GA) failed to maintain written policies and procedures which are current and complete. The GA's failure to maintain current and complete policies and procedures places the patients at risk for poor quality of care. Findings are: Review of the agency's policy and procedure manual lacked documentation of review and revision since 1/15/00. During an interview with the Owner on 07/17/07 at 11:30AM, the Administrator acknowledged that the policy and procedure manual needed to be reviewed and revised. REPEAT DEFICIENCY FROM 05/17/2006	H1008	Amended XI SR	

Brigit Durkin /owner/ 9/19/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1008	Continued From Page 6 SURVEY	H1008		
H1014	766.9(g) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (g) employ or contract for a sufficient number of staff to coordinate, direct and deliver services to patients accepted for care in accordance with prevailing standards of professional practice. This Rule is not met as evidenced by: Based on onsite visit, personnel record review and interview with the Owner, the Governing Authority (GA) failed to ensure that the agency employed sufficient staff to coordinate and direct patient care services. The GA's failure to ensure that there are adequate staff present for the coordination and delivery of patient care services places the patients at risk for poor quality of care. Findings are: On 07/17/07 at 8:45 AM, the surveyors arrived at the 36 Janice Lane in Selden, NY 11784. The office door was locked and no staff members were present. On the office door the Administrator has posted a note for the Department of Health that read "You have reached Caring Hands, If I am not here (Bridget Durkin) I may have stepped out. DOH please call me on my cell phone if I am not here".	H1014	SL Amended 1. Bridget Durkin/owner/9/19/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY. INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1014	Continued From Page 7 The surveyor called the cell phone number and left a message for the Owner to call back. The Owner never called the surveyors back. At 9:00 AM, the landlord stated that her father was able to reach the Owner and that the Owner would arrive in 30 minutes. During interview with the landlord, the landlord stated that the Owner is usually "In and out of the office everyday". During interview with the Owner at 9:20 AM, the Owner informed the surveyors that the agency's operating hours are from 10:00 AM to 4:00 PM Monday to Friday. The Owner could not provide an explanation for the lack of staff to coordinate patient care services during the survey. Additionally, review of employee files and request for contracts for staff revealed that the agency does not have staff to provide Speech Therapy (ST), Medical Social Worker (MSW) and home health aide (hha) services. These services are currently on the agency's license. During an interview with the Owner on 07/17/07 at 12:30 PM, the Owner stated that she does not have staff or the contract to provide ST, MSW, and hha services.	H1014		
H1036	766.9(I) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (I) appoint a quality improvement committee to	H1036	**766.9 (I)** **A) A multidiscipline Quality Improvement Committee will be held quarterly starting 10/17/07, including a designated consumer participant (Ms.Louise Kaiser) and physician (Dr,Desiree Sachse). . In addition the Policy and Procedure subcommittee (766.9 d), chaired by the Director of Nursing will present a written report on Policy and Procedure review and revision for discussion and approval to the Quality Improvement Committee.** **B) The administrative staff will send a written quarterly notice to each committee member. The notice will include place, date and time of the meeting including a tentative agenda. A copy of the notice and agenda will be filed in the administrative office along with a signed copy of the meeting's minutes and attendance sheet.** **C) All agency staff will be informed of the re-organization of the Quality Improvement Committee in writing by the Director of Nursing on 10/01/07.** **D) The administrative staff will perform bi-annual review of the files, which will contain the original notices, agendas and signed minutes; findings will be discussed in the Quality Improvement Committee.** Amended x1 10/1/07	

Bright Durkin Owner Operator 9/19/07 SR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 8 establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Rule is not met as evidenced by: Based on review of Quality Improvement (QI) meeting minutes and interview with the Owner, the Governing Authority (GA) failed to ensure the QI committee met four times a year and included a physician and a consumer and reviewed agency policies and procedures. The GA's failure to ensure that the QI committee met four times a year and included all required members places patients at risk for receiving	H1036	Amended X1	SR

Brigit Rusker / Owner / 9/19/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 9 poor quality care. Findings are: A request for QI meeting minutes from 2006 - 2007 was made by the surveyors during the entrance conference. The Owner could only provide two (2) meetings dated 09/08 and 10/05/06. The Owner could not provide documentation of any meetings conducted in 2007. The QI meeting minutes failed to include all the required members, both of the meetings lacked the attendance of physician and a consumer. The QI meeting minutes also lacked documentation that the agency reviewed policies and procedures pertaining to the delivery of the health care services provided by the agency. During an interview with the Owner on 07/17/07 at 11:00 AM, the Owner could not locate the QI minutes for this year and could not provide an explanation why the physician and consumer were absent from both 2006 meetings. REPEAT DEFICIENCY FROM 05/17/2006 SURVEY	H1036		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient,	H1142		

SR
Amended x1
Bright Owusu / owner
9/19/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 10 knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Rule is not met as evidenced by: Based on review of the agency's Policy and Procedure manual and interview with the Owner, the agency failed to develop comprehensive policies and procedures regarding the agency's maintenance of their Health Provider Network (HPN) account.	H1142	**766.9 (o)** **A) The governing body/operator of the agency developed a new tentative policy and procedure for HPN. (Plan will be submitted to the DOH for review and if necessary revision). HPN training has just begun and a new HPN coordinator will be trained online within the next two weeks.** **B) To prevent a re-occurrence of this issue and or similar issues a specific period for regulatory body updates and discussion will be included in the Quality Improvement Committee meeting starting 10/17/07.Inservice of designated personnel to access the HPN system will be ongoing.** **C) The governing body/operator will present pertinent data regarding HPN and other regulatory body information in the Quality Improvement Committee meeting.** **D) The governing body/operator will perform bi-annual review of minutes to ensure the QIC has adequately covered HPN and other regulatory body information accordingly.** Amended x1 SR	10/17/07

Knight Burkin
Owner - Operator
9/19/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 11 The agency's failure to ensure current information on the Communication Directory on the HPN places the agency at risk for not receiving the information provided on the HPN. Findings are: Review of the agency's HPN Policy and Procedure failed to address the agency's HPN coverage consistent with the agency's hours of operation, adherence to the requirements of the HPN user contract, and a procedure to ensure current and complete updates of the Communication Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum on a monthly basis. Additionally, the Policy and Procedure lacked date of review and implementation as well as approval by the Quality Assurance Committee and the Governing Authority. During an interview with the Owner on 07/17/07 at 1:00 PM, the Owner stated that "the agency has an account but does not access that often". The Owner could not recall when she had last accessed the HPN account. The Owner could not demonstrate access to HPN. The Owner stated that she accesses the HPN from her home. It should be noted that according to the HPN accounts management in Albany on 07/16/07, the HPN accounts management stated that currently the HPN account for Caring Hands Home Care Agency is an "inactive" account and the last time the HPN account was accessed by this agency was on December 8, 2006.	H1142	Amended XI SR	

Brigit Durkin / owner
9/19/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 12 REPEAT DEFICIENCY FROM 05/17/2006 SURVEY	H1142		
H1302	766.11(a) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (a) the development and implementation of written personnel policies and procedures, which are reviewed at least annually and revised as necessary. This Rule is not met as evidenced by: Based on review of personnel files, policy and procedure review, and staff interview, the agency failed to ensure personnel policy and procedures are reviewed at least annually and revised as necessary. Findings are: Review of policy and procedure manual documented that the personnel policies and procedures were last reviewed in the year 2000. During an interview with the Owner on 07/17/07 at 12:30 PM, the Owner acknowledged the survey findings and could not provide an explanation for the agency's failure to review and revise personnel policies and procedures at least annually. REPEAT DEFICIENCY FROM 05/17/2006 SURVEY	H1302	Amended x1	

Brigit Durkee / caregiver
9/19/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1350	Continued From Page 13	H1350		10/17/07
H1350	766.11(k) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (k) that an annual assessment of the performance and effectiveness of all personnel is conducted including at least one in-home visit to observe performance, if applicable. This Rule is not met as evidenced by: Based on review of personnel files and interview with the Owner, the agency failed to ensure that all health care personnel received an annual performance assessment which includes at least one (1) in-home visit observation in six (6) of six (6) employees that required annual performance evaluations. (Employees #1 through #6) The agency's failure to ensure that all employees receive annual performance evaluations which included at least one in-home visit observation places the patients at risk for receiving poor quality care. Findings are: Employee #1- documented an annual performance evaluation dated 06/03/07 but lacked documentation of at least one in-home visit observation. Employee #2 - documented an annual performance evaluation dated 07/11/07 but lacked documentation of at least one in-home visit observation. Employee #3 - lacked an annual performance	H1350	**766.11 (k)** **The Director of Nursing will ensure the following:** **A) According to the agency's Personnel Policy, all staff will** **Receive an annual performance review by their designated** **Supervisor, including at home-site evaluations for clinical staff** **Members starting 10/12/07. The Director of Nursing will provide** **The supervisor(s) with in-service training, reinforcing the** **Annual performance review process.** **B) Based on established written criteria all personnel files will** **Be reviewed by the Human Resource Committee (DON, Marilyn Magloglin RN and any other contracted RN if deemed necessary) quarterly or as needed.** **C) The review process will be ongoing. Written status reports** **Will be kept on file. The Director of Nursing will send a notice to staff regarding the annual performance evaluation process on 10/12/07.** **D) The Human Resource Committee will submit a bi-annual report to the Quality Improvement Committee regarding the status of the clinical employee performance reviews starting 10/17/07.** Amended x1 SR	

Bright Durkin Owner/operator 9/19/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1350	Continued From Page 14 evaluation for year 2006. This employee has been employed since September of 1995. Employee #4 - documented an annual performance evaluation dated 05/30/07 but lacked documentation of at least one in-home visit observation. Employee #5 - lacked an annual performance evaluation for year 2007. This employee was employed on 04/25/06. Employee #6 documented an annual performance evaluation dated 06/25/07 but lacked documentation of at least one in-home visit observation. During an interview with the Owner on 07/17/07 at 12:15 PM, the Owner stated that the evaluations were based on in-home visit observation. The Owner acknowledged that the annual performance evaluations lacked documentation of in-home visit observation. The Owner stated that employee #3 and #5 did receive their evaluations but they had not returned the signed evaluations to the agency.	H1350	**766.12 a (3)** **The owner will ensure the following:** **A) The agency's administrative staff developed a new filing system for the maintenance of records and reports. Statistical reports required by the DOH, meeting minutes, personnel records, grievances and complaints and or records related to patient care and services will be filed in a timely manner in specific white binders and will not be discarded until three years. The agency's operator accessed HPN on 09/19/07 to obtain statistical reports of 2005/2006 requested by the DOH and filed them on 09/20/07. The agency's operator will provide in-service to designed staff on how to utilize the HPN system.** **B) The operator and the quality improvement staff will submit quarterly statistical reports to the Quality Improvement Committee starting 10/17/07.** **C) Implementation of a new filing and reporting system.** **D) Reports will be submitted to the Quality Improvement Committee and administrative staff will perform bi-annual review of the files, which will contain the original notices, agendas and signed minutes; findings will be discussed in the Quality Improvement Committee.** 9/20/07 Amended	
H1404	766.12(a)(1) Records and reports 766.12 Records and reports. (a) The governing authority or operator shall ensure the prompt submission of all records and reports required by the department and that: (1) copies of the following records are retained on file at the principal administrative office in New York State of the home care services agency and available to the department upon request:	H1404		

Bright Durkin / owner / operator
9/19/07

SR

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1404	Continued From Page 15 (i) the license issued by the department to operate as a home care service agency; (ii) the certificate of incorporation and any amendments thereto, if applicable; (iii) partnership agreement, if applicable; (iv) certificate of doing business under an assumed name, if applicable; (v) contracts and other agreements related to delivery of patient care entered into by the operator; (vi) rules and bylaws of the governing authority and quality assurance committees, if applicable; (vii) current written operating policies and procedures; (viii) a current patient roster; and (ix) listing of all personnel. This Rule is not met as evidenced by: Based on on-site visit and interview with the Owner, the Owner provided the Certificate of Incorporation papers which revealed that the corporation was still inactive. Findings are: On 07/17/07, review of the Certificate of Incorporation papers, revealed that these were the same documents provided to the surveyor with the Plan of Correction submitted for the survey conducted on 05/17/06. The Owner stated that "the agency's accountant and the Division of Bureau of Taxation are trying	H1404	Amended x1	

Brigit Burker / owner 9/19/07

SR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1404	Continued From Page 16 to workout a payment plan, but there has been ongoing discussion of how much money is actually owed by the agency". Online verification on 07/16/07 of corporation status revealed that the corporation is an "Inactive". REPEAT DEFICIENCY FROM 05/17/2006 SURVEY	H1404		
H1432	766.12(a)(3) Records and reports 766.12 Records and reports. (a) The governing authority or operator shall ensure the prompt submission of all records and reports required by the department and that: (3) at a minimum, the following reports and records are retained by the home care services agency and available to the department upon request: (i) minutes of the meetings of the governing authority and the committees thereof which shall be retained for three years from the date of the meeting; (ii) records of all financial transactions directly related to delivery of patient care which shall be retained three years from the date of the transaction; (iii) personnel records, which shall be retained three years from the date of employee termination or resignation; (iv) records of grievances and complaints which shall be retained for three years from the date of	H1432	Amended X1	

Bright Duker / owner / SR
9/19/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	07/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE AGENCY, INC.	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1432	Continued From Page 17 resolution; (v) all records related to patient care and services; and (vi) any other records required to be kept by this Part or Part 765. This Rule is not met as evidenced by: Based on request for the Department of Health Statistical Reports for 2002, 2003, and 2005 and interview with the Owner, the Governing Authority (GA) failed to submit and maintain records of the required Statistical Reports prepared and submitted by the agency. Findings are: Upon request for Department of Health Statistical Reports, the Owner was only able to provide the report for 2004. During an interview with the Owner on 07/17/07 at 12:45 PM, the Owner stated that "I know they were all filed". REPEAT DEFICIENCY FROM 05/17/2006 SURVEY	H1432	Amended SR	

Brigit Burke
Owner / 9/19/07

PRINTED: 10/11/2007
FORM APPROVED

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0762A	A. BUILDING _____ B. WING _____	07/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE	4 WEST PROSPECT AVENUE MOUNT VERNON, NY 10550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full survey was conducted on 7/26 &7/27/07. A total of nine (9) clinical records were reviewed (#1 through #9). A total of ten (10) personnel records were reviewed (#1 through #10).	H 000		
H 304	766.2(a)(1) Patient service policies and procedures 766.2 Patient service policies and procedures: (a) The governing authority shall ensure for each health care service provided that: (1) written policies and procedures consistent with current professional standards of practice are developed and implemented for each service and are reviewed and revised as necessary. This RULE is not met as evidenced by: Based on review of the agency's policy and procedure manual and interview, the agency failed to develop a policy related to Criminal History Record Check (CHRC). Findings include: On review of the agency's Policy/Procedure manual, it was noted the agency did not have policy developed related to the CHRC. During an interview with the Administrator on 7/16/07, the administrator stated that the agency did not have a CHRC policy and was not aware that one was needed. Failure to have an Criminal Background Check Policy has the potential for the agency not having appropriate guidelines for staff to follow when	H 304	**766.2(a)(1) Patient Service Policies and Procedures** "During an interview with the Administrator on 7/16/07, the Administrator stated that the Agency did not have a CHRC policy and was not aware that one was needed." Branch personnel were confused about this when I spoke to them, as the surveyor did not arrive until 7/26/07, and was presented with our policy (attached), in place since 4/07 (updated since to reflect add'l. requirements by DOH) and told the Director of Clinical Services that this was "just what she was looking for". Please let me know if there is anything additional we need to do regarding this. *Addendum 10-30-07* *Please see attached NYS CHRC Policy 4(d) April 2007 and Criminal Background Checks-NYS 2(a) July 2007.*	Acceptable 11/1/07

ATE FORM
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0762A	A. BUILDING _____ B. WING _____	07/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE	4 WEST PROSPECT AVENUE MOUNT VERNON, NY 10550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H 304	Continued From Page 1 hiring new employees.	H 304	Agency sent copy of CHRC - acceptable DP 11/1/07	
H 510	766.4(b) Medical orders 766.4 Medical orders. (b) For purposes of this Part, authorized practitioner shall refer to a doctor of medicine, a doctor of osteopathy, a doctor of podiatry, a licensed midwife or a nurse practitioner authorized under federal and state law and applicable rules and regulations to provide medical care and services to the patient except as may be limited by third party contract. This RULE is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to include the amount, frequency, and duration for Medical Orders for Physical Therapy (PT) in two (2) of two (2) patient records reviewed, in which the patient was receiving PT services from the agency (#5, #9). Failure to include specific amount, frequency and duration in Medical Orders has the potential for the patient to receive inappropriate or inadequate care. Findings include: Patient # 5 was admitted to the agency on 1/17/05 with a diagnosis of Cervical Disc Displacement. The Plan of Care (POC) dated 6/28/07 ordered a PT evaluation. The PT evaluation was done on 6/29/07 and documented to continue PT for three (3) times per week for two (2) weeks. Subsequent PT	H 510	**766.4(b) Medical Orders** All Metro Health Care's policy for medical orders [attached – Exhibit A(1), (2) & (3) and B(1) & (2)] contains specific language regarding time frames for development of POC's as well as the need for indicating the specific services, plans for implementation as well as type, frequency and duration of visits/shifts. The Director of Clinical Services is responsible for the completion of POC's at the branch. The DCS shall consult with the Therapist before writing the orders to determine what specific interventions will be administered, how frequently and for how long. All active Therapy case files will be reviewed to assure that this verbiage is present in the POC. Moving forward, all incoming documentation will be reviewed before filing to assure that the POC is complete and accurate. Any changes in the therapy type, frequency and duration will be documented in the notes and an Interim Rx shall be sent to the MD for signature. This is discussed with all DCS's during orientation, and has been reviewed with the Mount Vernon DCS by the VP of Patient Services. Completion date 10/31/07.	

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0762A	A. BUILDING _____ B. WING _____	07/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE	4 WEST PROSPECT AVENUE MOUNT VERNON, NY 10550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE DATE
H 304	Continued From Page 1 hiring new employees.	H 304	**766.4(b) Medical Orders** All Metro Health Care's policy for medical orders [attached – Exhibit A(1), (2) & (3) and B(1) & (2)] contains specific language regarding time frames for development of POC's as well as the need for indicating the specific services, plans for implementation as well as type, frequency and duration of visits/shifts. The Director of Clinical Services is responsible for the completion of POC's at the branch. The DCS shall consult with the Therapist before writing the orders to determine what specific interventions will be administered, how frequently and for how long. All active Therapy case files will be reviewed to assure that this verbiage is present in the POC. Moving forward, all incoming documentation will be reviewed before filing to assure that the POC is complete and accurate. Any changes in the therapy type, frequency and duration will be documented in the notes and an Interim Rx shall be sent to the MD for signature. This is discussed with all DCS's during orientation, and has been reviewed with the Mount Vernon DCS by the VP of Patient Services. Completion date 10/31/07. *Addendum 10-30-07* *All medical charts will be monitored for compliance as documentation is reviewed by the DCS before filing, as well as during the Utilization Review Process. A random sample of charts is reviewed quarterly by the Department of Clinical Services during routine internal audits.*	
H 510	766.4(b) Medical orders 766.4 Medical orders. (b) For purposes of this Part, authorized practitioner shall refer to a doctor of medicine, a doctor of osteopathy, a doctor of podiatry, a licensed midwife or a nurse practitioner authorized under federal and state law and applicable rules and regulations to provide medical care and services to the patient except as may be limited by third party contract. This RULE is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to include the amount, frequency, and duration for Medical Orders for Physical Therapy (PT) in two (2) of two (2) patient records reviewed, in which the patient was receiving PT services from the agency (#5, #9). Failure to include specific amount, frequency and duration in Medical Orders has the potential for the patient to receive inappropriate or inadequate care. Findings include: Patient # 5 was admitted to the agency on 1/17/05 with a diagnosis of Cervical Disc Displacement. The Plan of Care (POC) dated 6/28/07 ordered a PT evaluation. The PT evaluation was done on 6/29/07 and documented to continue PT for three (3) times per week for two (2) weeks. Subsequent PT	H 510		

Accepted 11/1/07

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0762A	A. BUILDING _____ B. WING _____	07/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE	4 WEST PROSPECT AVENUE MOUNT VERNON, NY 10550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 510	Continued From Page 2 visits were made on 7/3, 7/6 and 7/9/07, however, there was no order from a Medical Doctor (MD) for the PT visits of 7/3, 6 and 7/9/07. Patient # 9 was admitted to the agency on 10/25/06 with a diagnosis of a Hip Fracture. The POC dated 10/24/06 ordered a PT evaluation. The PT evaluation was done on 10/31/06 and the therapist documented in his notes to continue PT two (2) times per week for six (6) weeks. However, there was no evidence that the therapist communicated this to the Medical Doctor (MD) or that a Medical order was obtained for these additional visits. The PT made visits to the home after the evaluation on 11/27 and 12/8/06 and discharged the patient on 12/8/07. The Medical record lacked evidence of Medical Orders for these additional visits. During an interview on 7/27/07 with the Director of Patient Services (DPS), the DPS stated that she assumed the physical therapist had obtained the Medical Order from the physician.	H 510		

CRIMINAL BACKGROUND CHECKS – NYS

Following is a list of forms to be used in NYS so that we may be in compliance with the CHRC regulations.

100 – CHRC Agency Request Form
101 - Authorized Person Designation Form
102 – Consent Form for Fingerprinting and CHRC
103 – Request for CHRC Instructions (2 pages)
103(a) – CHRC Cover Sheet
103(r) - Resubmission
104 – Expedited Review Request Form
105 – Subject Individual Termination Form
106 – Revocation of Authorized Person Designation Form

1. When an associate is hired who is to be the individual primarily responsible for this process, Form 101 is to be completed, notarized and submitted for approval. If/when this person leaves AMHC's employ, or a different person is authorized to manage the CHRC process, Form 106 is submitted.

2. When an applicant is extended a job offer, they are to sign Form 102 documenting their consent for the CHRC.

3. **Two sets of fingerprints** are taken on the approved FBI fingerprint cards and submitted with Form 103. The employee remains a provision employee pending the results of the CHRC.

4. If AMHC received notification that the employee must be re-printed, **two sets of fingerprints** shall be submitted with Form 103(r).

5. If a prospective employee has been fingerprinted previously since 9/1/06, Form 104 may be submitted with the prints requesting an expedited review.

6. If a letter comes from DOH "Pending Denial", the employee is immediately removed from all cases. If an employee wishes to appeal a negative hiring decision rendered by DOH they may do so, but may not work until a positive decision is returned.

7. If/when the employee is terminated or voluntarily leaves our employ, Form 105 is submitted notifying DOH of same.

8. *All CHRC related documents are to be filed in a separate file from the Personnel and Confidential files.*

NYS CHRC POLICY

AMHC will conduct a criminal history record check on prospective employees who will provide direct care or supervision to patients, residents or clients as per Article 36 of the Public Health Law who are hired or used on or after September 1, 2006

Nurses and other licensed health care providers are excluded from this regulation.

AMHC shall designate one or more authorized persons and shall submit the name, position and contact information for each authorized person to the NYS DOH in the form and format required by the Department. ["Authorized person (AP)" means each individual designated by a provider who is authorized to request, receive and review criminal history information]

Direct on-site observation is required for the first week the provisional employee or temp staff is used. After the first week, AMHC, may alternate weekly, direct on-site observation with off-site, telephonic evaluation until the CHRC determination is received. Off-site evaluation is conducted via a phone call to the care recipient. The on-site supervision must be completed by a nurse (RN or LPN) and the off-site by either a licensed health care professional or coordinator. AMHC shall implement the supervision requirements of the temporary employee by utilizing an individual employed by AMHC with a minimum of one year's experience working for a provider certified, licensed or approved under Public Health Law. The results of the observations must be documented in the temporary employee's personnel file and signed by the person providing the supervision.

No person who has been previously fingerprinted on or after 9/1/06 and whose fingerprints remain on file with the DOH, shall be required to undergo fingerprinting for purposes of a new criminal history record check. AMHC shall submit a request for an expedited review in lieu of a regular submission for in these individuals and they are subject to the supervision requirements.

Recordkeeping. AMHC shall, maintain, and keep current, a record of:
(i) a roster of current employees who were reviewed as of 9/1/06 and a list of their staffing assignments; such roster shall be submitted upon request of the DOH in a form and format specified by the commissioner.

Notifications. AMHC will immediately, but within 14 calendar days after the event, notify the Department, and document such notification occurred, when:
(1) any prospective employee who is subject to a criminal history record check withdraws an application for employment or is no longer being considered as a prospective employee.; or
(2) any employee who was subject to, and underwent, a criminal history record check is no longer employed by the provider.

Retention and disposal of information. AMHC shall maintain information necessary to demonstrate compliance with this regulation (a) of this section, for at least six years after the person ceases to be a subject individual, unless otherwise directed by DOH.

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full Survey was performed at Gentiva Health Services on August 03, 2007. Five (5) Patient Records were reviewed and are identified as Patients #1 to #5. Seven (7) Personnel Records were reviewed and are identified as Employees #1 to #7.	H 000		
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges; (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient. (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware	H 204	The BD / designee will provide the Gentiva Governing Body with a copy of the approved plan of correction. Additionally, the BD/designee will provide a quarterly update on the status of the plan of correction to Gentiva's Governing Body for their review and comment. Amended XT TN	10/5/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Neil Amin — Branch Director — 9/10/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 1 of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Rule is not met as evidenced by: Based on patient record review and staff interview, the agency failed to provide their patients with accurate information regarding their rights to be advised of the services to be provided in five (5) of five (5) records reviewed (Patients #1 to #5). The agency's failure to provide accurate information places the patients at risk for not being able to exercise all of their rights. Findings are: Review of the "Patient Rights and Responsibilities" of the "Home Care Consent" form in patient records #1 to #5 under the section noted as "Authorization for Payment/Assignment of Insurance Benefits" documented that "I certify that the information provided by me is correct. I authorize my insurance company (ies) including as appropriate Medicare, Medicaid, TriCare and other governmental programs to furnish any agency of Gentiva Health Services any and all information pertaining to my insurance benefits and status of claims submitted by Gentiva Health Services". It should be noted that the licensed home care agency cannot bill Medicare for services.	H 204	The BD / DCM will be responsible to ensure that the action items noted in the submitted plan of correction for H204 are completed as noted in the plan of correction submitted 8/27/07 and the amended plan of correction items noted herein. The specific action items are noted in detail on the plan of correction but a summary of the action items include: 1. BD/designee working with the Gentiva Forms Committee to approve revisions to the home care consent listing only the services and payers available through the licensed agency 2. MCP/designee completing a SOC audit for all new admissions ensuring that consents are filled out correctly and that the licensed consent addendum is completed reflecting the correct licensed agency services and payers. For any incorrectly completed consent and/or consent addendums, the MCP/designee will counsel the clinician and any subsequent incorrect consents and/or consent addendums will result in further disciplinary action up to an including termination. 3. The DCM/designee will trend the SOC audit data and develop and implement a plan to correct any identified issues. 4. The Branch Director/designee will ensure that patients understand what specific services and payers are available through the licensed agency through the inclusion of the licensed consent addendum (only the specific services and payers available through the licensed agency are noted on the addendum) in the licensed SOC packet. Amended 9/7 TN	

Noel Nuttoff, BD 9/10/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 2 Review of the agency's Admission Information Packet and patient records #1 to #5 included receipt of the agency's Home Care Consent. The consent documented that the agency is able to provide "RN (Registered Nurse), LPN (Licensed Practical Nurse/LVN (Licensed Visiting Nurse), Physical Therapy (PT), Medical Social Services (MSW), Transportation, Housekeeping (or Homemaker) - (HK/HM), Speech/Language Pathology (SLP), Home Health Aide (hha), Nutritional Services, Occupational Therapy (OT) and Hospice Services". The consent form failed to include Personal Care which is on the agency's license. Review of the agency's license does not include Transportation, Nutritional Services and Hospice Services. These noted services are not approved services that are included on the agency's license # 9511L039, that was issued by the New York State Health Department on 06/05/01. For example: Patient #1 was admitted to the agency on 07/09/07 with diagnoses of Diabetes Mellitus, Ulcer other part of Foot (left). Review of the Home Care Consent dated 07/09/07, the nurse checked on the consent that the agency is able to provide: RN, LPN, PT, MSW, DME, and Nutrition. The agency is not approved for DME (Durable Medical Equipment) and Nutrition services. The nurse failed to check other services that the agency is able to provide such as OT, SLP, and hha (home health aide) services. Patient #3 was admitted to the agency on	H 204	5. The MCP/designee will ensure that the homecare consent for patients #1 through #5 are corrected to reflect only the services and payers available through the licensed agency. 6. The MCP/designee will counsel the specific clinicians servicing patients #1 through #5 regarding the specific services and payer available through the licensed agency. Further incorrectly completed consents for the clinician, will result in further disciplinary action up to and including termination. 7. The DCM/designee will complete an in-service for the clinical staff on the specific services and payers available through the licensed agency as well as how to complete the licensed consent addendum. 8. The DCM/designee will ensure that newly hired clinicians are oriented on the specific services and payers available through the licensed agency and how to complete the licensed consent addendum. Accepted 9/24/07 TD Amended XT	

Walter Mitchell, BO 9/10/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 3 06/29/07 with diagnosis of Aftercare Following Total Hip Replacement. Review of the Home Care Consent dated 06/29/07, the nurse checked on the consent that the agency is able to provide other services such as DME, and Respiratory Therapy (RT). The agency is not approved to provide for DME and RT services. Patient #4 was admitted to the agency on 07/11/07 with diagnoses of Colon Cancer, Dibility, and Chronic Airway Obstruction. Review of the Home Care Consent dated 07/11/07, the nurse checked on the consent that the agency is able to provide DME, Nutrition and RT services. The agency is not approved to provide for DME, Nutrition and RT services. During an interview on 08/03/07 at 11:20AM with the Director of Clinical Management, the DCM acknowledged that the patient's consent forms and the Patient Information Packet are both used for the licensed and the certified agency services.	H 204		
H 404	766.3(b) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and	H 404	Amended 9/4/07 TN	

Wolf Unterberg, MD 9/4/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 4 rehabilitation potential. This Rule is not met as evidenced by: Based on review of the patient records and staff interview, the agency failed to ensure that a Plan of Care is established for all patients receiving agency's services. This was evident in one (1) of five (5) records reviewed (Patient #5). The agency's failure to establish a Plan of Care for all patients receiving agency's services fails to ensure that the agency provides the required services to meet the patient's needs and has the potential for negative patient outcome. Findings are: Patient #5 was admitted to the agency on 07/03/07 with the diagnoses including Aftercare Following Surgery and Cellulitis. The patient record documented that the patient had an Abscess of the Left Groin. The SN (Skilled Nurse) visit notes from 07/03/07 to 07/11/07 documented that the SN was providing wound care to the patient's left groin. It should be noted that the patient's record lacked documentation of the Plan of Care. The SN's initial patient assessment that was performed on 07/03/07 documented the patient's wound, the required wound care and the SN visit frequency and duration. The record further lacked documentation of an interim physician order for the SN to provide the wound care and the required wound care regime. During the survey the Manager of Clinical Practice presented to the surveyor the established Plan of Care, one month after the	H 404	A copy of the tracking tool referenced in the original plan of correction dated 8/27/07, is included in this addendum as attachment #1. The tracking tool is entitled, Clinical Associate Assignment Tracking Log (attachment #1). The MCP/designee will complete the Clinical Associate Assignment Tracking Log for all new patients. Upon completion of the patient plan of care the MCP/designee will write a diagonal line through the Patient Name box in red ink and initial and date on the upper right hand corner to indicate that the plan of care was completed, reviewed, signed and processed to be mailed/faxed to the physician for signature. The DCM/designee will audit the Clinical Associate Assignment Tracking Log on a weekly basis to ensure that all patients have a completed plan of care within 7 days of start of care. The DCM/designee will take disciplinary action for any clinician not following the process and/or not completing the plan of care within 7 days of start. Continued deficiencies with the process may result in further disciplinary action, up to and including termination. Amended XT	**Initiated 8/24/07 and ongoing**

Need Nurse, BD 9/14/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 5 start of care date. The Plan of Care was signed and dated "07/03/07" by the nurse when the Plan of Care was actually established on 08/03/07. During interview on 08/03/07 at 12:20PM with the Manager of Clinical Practices and the Director of Clinical Management, the Manager stated that "I know that I'am late with the orders". The Manager further stated that she does not review the received SN visit notes.	H 404	The analysis completed by the DCM to ensure that a plan of care was present and signed by the physician and that all orders were signed within 30 days, as referenced in the original plan of correction submitted 8/27/07, was done utilizing the "Patient Census for Office 0146" which is included as Attachment #2. The patients that are crossed out are Department of Social Service (DSS) Personal Care Aide cases that Gentiva is not required to have physician orders on since the cases belong to the DSS. All other patients are Gentiva licensed agency patients. The DCM placed a check mark to the left of each patient upon verification that a plan of care was present and signed by the physician and that all orders for the patient were signed within 30 days. The DCM signed attachment #2 to indicate verification and completion of the record audit. A copy of the signed plan of care for patient #5 is included in this amended plan of correction. (The amended response to tag prefix H404 is continued on a separate page following the same response format since there is not sufficient space provided on the form.) TN	8-24-07
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Rule is not met as evidenced by: Based on patient record review and staff interview, the agency failed to ensure that all medical orders are authorized and signed by the physician within thirty (30) days after admission to the agency. This was evident in two (2) of five (5) records reviewed (Patients #3 and #5). The agency's failure to ensure that all medical orders are signed by the physician within thirty (30) days, places the patients at risk for receiving unauthorized agency's services and poor quality	~~H 514~~ H514	A copy of the signed physician orders for patient #3 and #5 are included in this amended plan of correction. The BD / designee will provide the Gentiva Governing Body with a copy of the approved plan of correction. Additionally, the BD/designee will provide a quarterly update on the status of the plan of correction to Gentiva's Governing Body for their review and comment. 10/5/07 Amended XT TN	

Noel Mutoff, BD 9/10/07

ID Prefix Tag:	Provider Plan of Correction (continued):	Complete Date:
H404	The BD / designee will provide the Gentiva Governing Body with a copy of the approved plan of correction. Additionally, the BD/designee will provide a quarterly update on the status of the plan of correction to Gentiva's Governing Body for their review and comment.	10/5/07

The DCM will be responsible to ensure that the action items noted in the submitted plan of correction for H404 are completed as noted in the plan of correction submitted 8/27/07 and the amended plan of correction items noted herein. The specific action items are noted in detail on the plan of correction but a summary of the action items include:

1. MCP/designee ensuring that a plan of care is completed for all new patients through the utilization of the Clinical Associate Assignment Tracking Log (attachment #1). The DCM/designee completing a weekly audit of the Clinical Associate Assignment Tracking Log to ensure compliance with the process and completion of plan of care within 7 days. DCM/designee taking disciplinary action for non-compliance with the process.
2. DCM/designee completing an in-service for the professional caregivers reviewing the need for a plan of care being completed within 7 days of the start of care and the need for physician signature on such plan of care within 30 days.
3. The DCM/designee ensuring that newly hired professional caregivers are oriented to the requirement that a plan of care being completed within 7 days of the start of care and the need for physician signature on such plan of care within 30 days.
4. The DCM completion of an audit of all active licensed cases (excluding DSS cases) to ensure that a plan of care and physician orders were present and signed within 30 days.
5. Verification that a signed plan of care has been received for patient #5.
6. Counseling of MCP and field RN for patient #5 regarding the need for timely completion of plan of care.

Attachments reviewed
Accepted 9/24/07 TW

Neal Metcalf, BD 9/10/07

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From Page 6 of care. Findings are: Patient #3 was admitted to the agency on 06/29/07 with diagnosis of Aftercare Following Total Hip Replacement. The Plan of Care dated 06/29 - 08/29/07 lacked physician's signature. During an interview with the Manager of Clinical Practices (MCP) on 08/03/07 at 12:30 PM, the MCP was informed of the survey findings. The MCP acknowledged the survey findings and could not provide an explanation why the orders were still not signed. Patient #5 was admitted to the agency on 07/03/07 with the diagnoses including Aftercare Following Surgery and Cellulitis. The Plan of Care dated 07/03/07 to 08/31/07 lacked physician's signature to authorize the services to be provided by the agency. Refer to H0404 - Plan of Care. During interview with the Director of Clinical Management (DCM) and Manager of Clinical Practices (MCP) on 08/03/07 at 12:30 PM, they were informed of the survey findings. The MCP acknowledged the survey findings.	H 514	The BD/DCM will be responsible to ensure that the action items noted in the submitted plan of correction for H514 are completed as noted in the plan of correction submitted 8/27/07 and the amended plan of correction items noted herein. The specific action items are noted in detail on the plan of correction but a summary of the action items include: 1. CTC, under the direction of the MCP, will review the physician order tracking report on a daily basis and bring any orders over 21 days old to the MCP for prioritization. The MCP will review the physician order tracking report with the CTC on a weekly basis to ensure that orders are obtained within 30 days and any orders over 21 days have been properly prioritized for follow-up. 2. Administrative and clinical staff have been re-educated and counseled regarding the all physician orders being obtained within 30 days of start of care. Continued non-compliance with the above established process will result in further disciplinary action, up to and including termination. 3. New employees responsible for physician order tracking will be oriented on the established process and the requirement that physician orders be signed within 30 days of start of care. 4. The Clinical Associate Assignment Tracking Log process indicated under tag H404 to ensure that plans of care are completed within 7 days of the start of care, will also apply under tag H514 wherein the physician order needs to be signed within 30 days. The physician order tracking process referenced under item #1 above will include plans of care. Attachments previously Accepted 9/24/07 TD Amended 9/4 TN	
H 722	766.6(a)(10) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (10) a discharge summary when the patient is	H 722		

Noel Mitchell, BD, 9/4/07

New York State Department of Health

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE OATE
H 722	Continued From Page 7 discharged from the agency including: (i) documentation of discharge planning preparation; (ii) notification to the patient's authorized practitioner; (iii) reasons for discharge and date of discharge; (iv) summary of care given and patient's progress; (v) patient status upon discharge including a description of any remaining needs for patient care and supportive services; (vi) patient or family ability to self-manage in relation to any remaining problems; and (vii) recommendations and referral for any follow-up care, if needed. This Rule is not met as evidenced by: Based on patient record review and staff interview, the agency failed to ensure that the patient care record documented the patient's discharge plan, reason for the discharge, that the patient and the physician were notified/informed regarding the pending discharge and the discharge summary. This was evident in three (3) of five (5) records reviewed (Patients #2, #3 and #5). The agency's failure to ensure that the patient and the physician have been informed about the patient's discharge, fails to ensure that an appropriate and safe discharge plan has been established for the patient and any required follow-up care/referral has been initiated to meet the patient's needs.	H 722	The record review to ensure completion of a discharge summary for every discharged patient referenced in the original plan of correction dated 8/27/07, will be completed by the MCP/designee as each patient is discharged. The DCM/designee will ensure compliance with this requirement by reviewing the comprehensive chart audits for discharged patients on a monthly basis. A copy of the discharge summaries for patients #2, #3 and #5 are included in this amended plan of correction. The BD / designee will provide the Gentiva Governing Body with a copy of the approved plan of correction. Additionally, the BD/designee will provide a quarterly update on the status of the plan of correction to Gentiva's Governing Body for their review and comment. The DCM will be responsible to ensure that the action items noted in the submitted plan of correction for H722 are completed as noted in the plan of correction submitted 8/27/07 and the amended plan of correction items noted herein. The specific action items are noted in detail on the plan of correction but a summary of the action items include: 1. MCP/designee completing a chart audit for every discharged patient to ensure completion of a discharge summary. The DCM ensuring compliance with this process through a monthly review of the chart audits for discharged patients. Amended 9/7	8/30/07 and ongoing 10/5/07 TN

Noel Wentzel, BD 9/10/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 722	Continued From Page 8 Findings are: Patient #3 was admitted to the agency on 06/29/07 with diagnosis of Aftercare Following Total Hip Replacement. The Plan of Care dated 06/29 - 08/29/07 ordered Skilled Nursing (SN) one (1) x week x two (2) weeks and two (2) x week x three (3) weeks. Review of the record lacked documentation of SN visit notes after 07/12/07. During an interview with the Director of Clinical Management (DCM) and Manager of Clinical Practices (MCP) on 08/03/07 at 12:30 PM, they were informed of the findings and were given an opportunity to provide an explanation. At 2:00 PM, the MCP stated that the patient was discharged from the agency on 07/12/07 and the discharge summary was done, yet the agency is unable to locate the discharge summary. Patient #5 was admitted to the agency on 07/03/07 with the diagnoses including Aftercare Following Surgery. The Plan of Care dated 07/03/07 to 08/31/07 ordered the SN to provide wound care to the patient's left groin. The record documented that the last SN visit note was dated 07/11/07. The record lacked documentation of the patient care services and the patient's status from 07/12/07 to 08/03/07. The record also lacked documentation of any discharge planning and if any referral and /or follow-up care was required. The record further lacked documentation of the patient's status upon discharge from the agency's services. During interview on 08/03/07 at 1:50PM with the DCM, the DCM stated that the nurse's last visit	H 722	2. DCM/designee completing an in-service for professional caregivers and MCPs identifying the requirements of discharge planning which include complete documentation, physician notification, discharge status, summary of care, and identification of continuing needs and supportive services. Caregiver and MCP non-compliance with this requirement will result in disciplinary action, up to and including termination. 3. Re-education and counseling of the caregivers identified for patients #2, #3, and #5 regarding the comprehensive discharge planning requirements and completion of discharge summaries. Continued deficiencies will results in further disciplinary action, up to and including termination. 4. Orientation of newly hired professional caregivers regarding the discharge planning requirements and completion of discharge summaries. Attachments reviewed Accepted 9/24/07 TD Amended 9/10/07 Wed Mental, BD	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 722	Continued From Page 9 was on 07/11/07 and that the nurse failed to document the discharge summary for the patient's record. Patient #2 was admitted to the agency on 06/18/07 with the diagnosis including Right Total Hip Replacement. The Plan of Care dated 06/18/07 to 08/16/07 ordered SN and PT (Physical Therapy) services. The record documented the last SN visit note was dated 06/18/07. The record also documented that the patient refused the SN visit on 06/21/07. The record lacked documentation of the patient care services and the patient's status from 06/22/07 to 08/03/07. The record lacked documentation that the nursing supervisor and/or the nurse had contacted the patient for a subsequent visit and the patient's status after 06/21/07. The record also lacked documentation of any discharge planning, if any referral and/or follow-up care required, that the patient and the physician were informed/notified about the discharge and the patient's status upon discharge. During interview on 08/03/07 with the DCM at 1:50PM, the DCM stated that the nurse failed to document the discharge summary for the patient's record.	H 722		
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined	H1002	Amended ✓ TN	

Noel Mintaf, BD 9/10/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 10 in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on review of the patient records, patient admission information packet and staff interview, the Governing Authority failed to be responsible for the management and operation of the agency. The Governing Authority's failure to be responsible for the management and operation of the agency places all patients at risk for poor patient care practices. This was evident in the following deficiencies: H0204 - Patient Rights - 76601 (a) (1) H0404 - Plan of Care - 766.3 (b) H0514 - Medical Orders - 766.4 (d) H0722 - Patient Care Record - 766.6 (a) (10)	H1002	The BD/designee will provide the Gentiva Governing Body with copies of the Quality Improvement Committee and Professional Advisory Committee meeting minutes and reports on a quarterly basis in order to update them regarding the agency operations and management. The BD/designee will also provide the Gentiva Governing Body with a copy of the approved plan of correction and deficiencies and a status update on the plan of correction, on a quarterly basis. Unacceptable 9/24/07 TW The plan lacks effective interaction with the HA The plan lacks what follow up the HA will take re the information provided	10/5/07 and ongoing
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional	H1036	Amended 9/10/07	

Noel Mitchell, BD 9/10/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 11 persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Rule is not met as evidenced by: Based on the review of the Quality Improvement Committee (QIC) meeting minutes for the year 2006 and staff interview, the Governing Authority failed to meet the required four (4) times per year. The Governing Authority's failure to ensure that the QIC meets four times per year, places the patients at risk for the agency not being aware of trends/practices that would affect the delivery of patient care services. Findings are:	H1036	The BD has developed a list of items that must be reported and reviewed during the Quality Improvement Committee meetings so as to ensure that all required indicators are addressed. The list of items includes: 1. Active Census Number and date. 2. Number of Admissions and period reported. 3. Number of Discharges and period reported. 4. Number and summary of Complaints and period reported. 5. Number and summary of Incidents and period reported. 6. Number and summary of Adverse Events/Infections and period reported. 7. Chart Audit Findings, Trends, and Total Number Completed for the following specific audits: a. Start of Care record audit b. Clinical Record Review (CRR) audits for active and discharged patients. 8. Review of policies and procedures – New and Revised. The BD/designee will provide the Gentiva Governing Body with copies of the Quality Improvement Committee and Professional Advisory Committee meeting minutes and reports reviewed during such committee meetings, on a quarterly basis. The BD/designee will obtain written acknowledgement and feedback if appropriate from the Gentiva Governing Body, regarding their review of the referenced committee meeting minutes and reports. Amended x5 TN	10/5/07 and ongoing **10/5/07 and ongoing**

Noel Mitchell, BD 9/10/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9511L039	A. BUILDING _____ B. WING _____	08/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	877 EAST MAIN STREEY RIVERHEAD, NY 11901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 12 Review of the QIC meeting minutes for 2006, documented that the committee had met on 02/07/06, 04/18/06 and 10/24/06. For the month of July 2006, the binder contained a piece of paper that documented that the meeting was cancelled due to scheduling conflicts. The section in the binder that was labeled December 2006, lacked the documentation of the QIC meeting minutes. During interview on 08/03/07 at 1:40PM with the Director of Clinical Management (DCM), the DCM stated that she was not sure if the committee had met after 10/24/06. It should be noted that during the survey, the agency did not provide any additional QIC meeting minutes for the year of 2006.	H1036	Accepted 9/24/07 TN Amended 10/1	

Noel Mentaff, BD 9/14/07

CI Feb 2012 schedule

Teresa A. Nolan to: Cheryl B Phoenix 01/05/2012 07:24 AM

Cc: Mikhail Pankov, Suman Raina, Eileen Warner, Marie S Boyer

The CI schedule for Feb is:

2/1/12 Brookhaven Hospice PCV (Prov #33-1537) SR* TN

2/3 SR office/offsite

2/6 SR office/offsite

2/6 - 2/7 Long Island Healthcare (Lic # 1330L001) EW* MB

2/10 SR office/offsite

2/14 - 2/15 Gentiva PCV TN* EW

2/15 - 2/16 St Mary's (Lic# 1191L002) MB* SR

2/17 SR office/offsite

2/20 Holiday

2/24 SR office/offsite

2/27- 3/2 Brookhaven Hosp Home Health Agency (Prov #33-7108) SR* TN EW MB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An Complaint Survey was initiated at Americare CSS on 11/19/07 and the findings resulted in an Extended Survey from 11/19-12/27/07. Americare CSS services a Special Needs Population which are patients with secondary diagnoses involving mental health, the mentally retarded, and/or developmentally disabled that preclude their independence in Activities of Daily Living. Nineteen (19) clinical records were reviewed and identified as Patients #1 - #19. Eight (8) home visits were made to Patients #1, #3, #4. #5. #8, #14. #14, #17 and #18. The patients were visited in there homes which were Adult Care Facilities (ACF). Fourteen (14) personnel files were reviewed and identified as Employees #1 - #14. Certified copies of the clinical records were requested on 11/27/07. The certified records were received in the Central Islip (CI) office on 12/06/07. Record reviews and interviews were conducted from the CI office. The exit conference was conducted on 12/27/07. Based on the Extended and Complaint Survey, the agency was found to be out of compliance with the following Conditions of Participation: 484.14 Organization, Services, Administration	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB -UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 000	Continued From page 1 484.18 Acceptance of Patients, Plan Of Care, Medical Supervision 484.30 Skilled Nursing Services	G 000		
G 101	484.10 PATIENTS RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. The STANDARD is not met as evidenced by: Based on home visits (HV), record review, Policy and Procedure review, and staff interview, the agency failed to ensure that the patient has access to the information regarding the patient rights. This was evident for six (6) of nineteen (19) records reviewed and four (4) of eight (8) home visits. (Patients #1 HV, #3 HV, #4, #8 HV, #9, and 14 HV) The agency's failure to ensure the patient's access to the information on the patients rights places the patients at risk for not being able to exercise their rights as needed. The findings include: Patient #1 (HV) was admitted to the agency on 07/03/04 with diagnoses of Diabetes Mellitus and Schizophrenia. A home visit was made to this patient (who resides in a Adult Care Facility (ACF) on 11/20/07 at 7:05 AM. During the visit, the admission folder (which the agency provides to the patient during the initial visit) was requested	G 101	**G 101 Plan of Rights (Standard)** **Education:** All Nursing staff have been in-serviced regarding the Patient BOR and Complaint Procedure/ DOH hotline #. **Monitoring:** Americare CSS Supervising Staff will be visiting all the Adult Care facilities on a weekly basis: (See attached calendar #2) as evidenced by a written supervisory note (See attachment # 3 Supervisory Form). The purpose of these visits is to ensure that patients are aware of their BOR, complaint procedure & DOH hotline #., and to ensure the supervision of skilled nursing services in accordance to the patient's POT.. • Ensure that the DOH hotline # is posted in view within the facility. The Supervisory reports will be reviewed and initialed on a weekly basis by the DPS. On an annual basis the start of the new year all active patients will be given another copy of their Bill of Rights & DOH hotline #. **Responsible Person:** DPS for each branch is responsible for oversight. Accepted 1/14/08 TW	Jan. 10, 2008 (Westbury) & Jan. 16, 2008 (Suffern)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 101	Continued From page2 For review. The Nursing Supervisor stated that information would be "kept with the ACF Administrator". The Nursing Supervisor not the ACF Administrator could locate the patient's admission folder. There was no explanation provided by the Nursing Supervisor and/or the Administrator as to the inability to locate the patient's admission folder which includes patient Bill of Rights and a procedure to lodge complaint. Patient #8 (HV) was admitted to the agency on 10/18/07 with diagnoses of Diabetes Mellitus, Long Term Use of Insulin, Congestive Heart Failure, Therapeutic Drug Monitoring and Schizophrenia. A home visit was made to this patient (who resides in an ACF) on 11/2/07 at 9:45 AM. The admission folder that is given to the patient's during initial visit from the Skilled Nurse (SN) was requested for review. The Nurse stated that the patient "does not have that information since the SN usually gives that information to the ACF Administrator or the copy is kept in the patient's mini chart which is kept locked in the agency's office". The patient would not be able to get the information on Patient Bill of Rights/Complaint Procedure after hours in case the patient wanted to lodge a complaint with the Department of Health. It places the patient at risk for not able to exercise all her patient rights. Patient #14 (HV) was admitted to the agency on 05/10/07 with diagnoses including Diabetes Mellitus and Psychosis.	G 101		7a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 101	Continued From page 3 The clinical record documents that the patient signed his home care consent. The assessment dated 5/10/07 documents: "Materials were given to the ACF (Adult Care Facility) Administrator". During home visit on 10/20/07 at 7:00AM, the patient (who resides in an ACF) stated that he did not recall receiving any information on his patient rights. Patient #3 (HV) was admitted to the agency on 02/16/07 with diagnoses of Coronary Atherosclerosis. Congestive Heart Failure, Lower Leg Injury, and Hypertension. During home visit on 11/20/07 at 11:00AM, the patient (who resides in an ACF) stated that he "did not receive" any information on his rights. The nursing visit nurse had in her possession the patient's yellow copy of the consent form. The patient was interviewed and stated that he was "not given" a copy of the consent. Bill of Rights and complaint procedure. The agency Director of Patient Services (DPS) was present during the interview and did not provide and explanation.. Patient #9 was admitted to the agency on 09/04/07 with diagnoses including Mental Retardation and Hypertension. The clinical record documents that the patient signed his home care consent. The assessment dated 09/04/07 documents: "Material were given to the ACF Administrator".	G 101		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 101	Continued From page 4 During interview with the Director of Patient Services (DPS) of Brooklyn, who was appointed by the parent agency to deal with Department of Health issues, on 11/27/07 at 11:00AM, the DPS stated that the patients "lose the information" and therefore the "ACF keeps the information for the patient". The DPS could not verify if the patient was ever given a copy of the patient's rights. Patient #4 was admitted to the agency on 10/06/06 with the diagnosis including Diabetes Mellitus Type II. The clinical record documents that the Skilled Nurse completed the initial patient assessment on "10/06/06" at which time the SN "discussed with the patient regarding the home care service agreement, State Hotline number and the patient's Bill of Rights". The clinical record documents that the patient signed the consent for home care services dated "10/06/06". The clinical record and the initial patient assessment lacked documentation that the agency had provided to the patient in writing, the patient's Bill of Rights and the State Hotline number to lodge complaints. The nurse documented "Discussed" under each section regarding this information. During interview on 11/27/07 at 1:00PM, the agency's Nursing Supervisor and the DPS, were unable to provide explanations. The agency's "Assessment/Reassessment with Medical Supervision" policy which was undated documented on page 2: ".....Upon acceptance	G 101		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 101	Continued From page 5 into service and advance to providing care, the patient/significant other is provided both verbal and written information and agency and services to be provided. The patient/significant other is given but not limited to the following information: Bill of rights and responsibility.....DOH (Department of Health) Hotline #...Access to care after hours.... Complaint grievance process....." The agency failed to ensure that the staff provided the patients with the Patient Rights information and that the patients had access to this information as per the agency's Policy and Procedure.	G 101		
G 121	484.12(c) COMPLIANCE W/ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on home visit observations and staff interview, the agency failed to maintain patient confidentiality; based on accepted professional standards and principles that apply to staff providing home care services in the community as required. This was evident for Patient #8. Failure to maintain patient confidentiality in accordance with the accepted professional standards and principles places the patients at risk for unnecessary disclosure of patient information. The findings include: A home visit was made to Patient #1 (who resides	G 121	**G 121 Compliance with Acceptable Professional Standards (Standard)** **Monitoring:** Supervisory staff will make weekly visits to the ACFs to monitor & evaluate the actual staff practices. • Are staff members following the policy and procedure as it is written in the manual? • Do the staff members need counseling or training? • Are managers adequately monitoring staff practices? Supervisor's will submit weekly summary, DPS will review weekly summaries. Based on the Supervisory visit findings in-service education will be arranged & provided on an on-going basis as needed. **Responsible Person:** DPS for each branch office will provide oversight and is responsible to enforce regulation. Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices.	accepted 1/14/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 6 In a Adult Care Facility (ACF) on 11/20/07 at 7:05 AM. During the visit, the Nursing Supervisor was observed talking in a loud voice about Patient #8 (who resides at another ACF) in the dining area. There were 3-5 patients in the dining area. On 11/20/07 at 8:50AM, the nurse and Nursing Supervisor were observed discussing Patient #8. The agency staff used the patient's name several times during the conversation in an open area where other patient's were observed to be sitting around and drinking coffee. On 11/20/07, the Director of Patient Services (DPS) from Brooklyn office who was appointed by the parent agency to deal with Department of Health issues and the DPS from Westbury office were informed of the observations. The administrative staff could not provide and explanations. The agency policy and procedure for "HIPAA PRIVACY NOTICE" which was undated documents that the policy applies to all "Americare workers, contractors, Vendors, ACF staff and other professionals PHI Related Information, in the course of their work. It details pertinent definition, who may receive PHI Related Information, in–service education requirements, confidentiality and disclosure...." The policy and procedure further documented That the "Federal law requires us to: Make sure that your medical information is kept private Give you this notice of our legal duties and privacy practices related to your medical information. Follow the terms of the privacy notice that is currently in effect."	G 121		
G 122	484.14 ORGANIZATION, SERVICES &	G 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 122	Continued From page 7 ADMINISTRATION This CONDITION is not met as evidenced by: Based on clinical record review, home visits, review of the agency's On Call Log, review of Policies and Procedures, review of the agency's Performance Improvement Committee Meeting minutes, and interviews, the Governing Authority (GA) failed to adequately oversee the management of the agency. Findings include: The GA failed to ensure the provision of safe and quality care to the agency's special needs population of patients with secondary diagnoses involving mental health, the mentally retarded, and/or developmentally disabled that prelude their independence in the activities of daily living as evidenced by: Failure to ensure the supervision of the Skilled Nursing Services Failure to ensure that the Skilled Nursing Services were provided in accordance with the patient Plan of Care Failure to ensure that the nursing staff coordinated care with the physician and other staff involved with the patients care including the Adult Care Facility (ACF) staff Failure to ensure that nursing staff reported changes to the physician and revised the patient Plan of Care to reflect the patient needs	G 122	**G 122 Organization, Services, Administration (Condition)** **How the Governing Authority is going to take responsibility for the corrective action for the Condition:** The DPS of each branch is responsible for oversight of Supervisory staff and will provide written weekly summaries to the Administrator/Governing Authority. Weekly meetings (ongoing) will take place with the Administrator & DPS to ensure that the POC is being adhered to. On a quarterly basis all findings will be reported to the Professional Advisory Committee/Board. Americare CSS Administrator/Governing Body (VP of Operations) will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. Accepted 1/14/08 TN	

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 122	Continued From page 8 Failure to ensure that the patients received medications and treatments in accordance with the Patient Plan of Care Failure to ensure supervision of the home health aide services Failure to ensure the patient has access to information on Patient Rights Failure to ensure that the staff respect the confidentiality of patient information during their presence in the ACF Failure to ensure the implementation of the agency's Policies and Procedures Failure to ensure the implementation of the corrective action plan for the Statement of Deficiencies for the Complaint Survey of 06/04/07. Refer to G101, G128, G133, G138, G145, G158, G159, G168, G173, G176, G229, and G236. The cumulative effect of these systems failures resulted in the agency's inability to ensure the provision of safe patient care practices that resulted in poor Diabetic management for patients #1 and #14, poor medication management for the special needs patients serviced by this agency, and places all agency patients at risk for unsafe and poor quality healthcare.	G 122		
G128	484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and	G128		TD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 128	Continued From page 9 responsibility for the operation of the agency. This STANDARD is not met as evidenced by: Based on clinical record review, home visits (HV) review of the Performance Improvement (PI) Audit for October 2007, staff interviews, review of the agency's On Call Log, and review of the agency's Policy and Procedures, the Governing Authority (GA) failed to ensure and implement the full responsibility for the safe delivery of patient care services for the special needs population of patients with secondary diagnoses involving mental health, the mentally retarded, and/or the developmentally disabled that prelude their independence in the activities of daily living which are serviced by this agency. The findings include: The GA failed to oversee the provision of nursing services to patient #1 HV which resulted in failure to provide a nursing visit on a weekend, "talking" via telephone to an unlicensed and untrained person at the Adult Care Facility (ACF) through the drawing up of Insulin and not investigating this incident until two (2) months later. Refer G158, G173, and G176 of this report. The GA failed to ensure the implementation of the Plan of Correction of the Complaint Survey of 06/04/07. The PI Audits for October 2007 and Plan of Correction Updates for October 2, 2007 continue to document the agency's failure to develop a complete Plan of Care, provide care in accordance with the Plan of Care, and supervise the home health aides. The audits documented that the agency had not met the thresholds for compliance to ensure that the corrective actions	G 128	**G 128 Governing Authority (Standard)** All Adult Care Facility Owners/Administrators were given 30-day notice verbally and in writing. All active patients were provided with a letter and a list of alternate providers (patient choice). Americare CSS will continue to provide care until the transition to another provider is complete. (See attachment # 5 Letters). **Americare CSS will maintain a log of the transition of active patients along with the completion date (See attachment # 6 Termination Log).** DPS provides a written summary with a copy of the transition log to the Administrator/Governing Authority on a weekly basis. Americare Supervisory staff will make weekly visits to the ACFs to ensure services are rendered in accordance to the POT. The Supervisor will alert the DPS of their findings. Americare DPS is responsible to develop and review the nursing schedule (a month in advance) to ensure services are being rendered in accordance to the Patient's Plan of Care. DPS will report the findings to the Administrator/Governing Authority The DPS submits a copy of the on-call calendar and log to the Administrator on a monthly basis for review. Any problems with staffing are immediately reported by the DPS to the Administrator for resolution. The VP of Operations has overall responsibility to ensure appropriate staff to implement safe delivery of care under business agreement. VP of Operations is ultimately responsible to ensure the ACFs are appropriately staffed and operating in accordance to the all Federal and State Regulations governing home care. Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 128	Continued from page 10 in the Plan of Correction for the Complaint Survey of 06/04/07 were met. The GA failed to oversee and monitor the PI activities. This was evident by repeat deficiencies in G158, G159 and G229. Review of the On Call Log and interviews documented problems with the agency's availability during off hours. During interviews with agency staff, the staff verbalized the problem with nursing availability especially on the weekends. This resulted in missed visits, missed Insulin doses, poor oversight of the patients medication regimen, and poor quality nursing care for this special needs population. Refer to G158, G159, G173, and G176 of this report. The GA's failure to assume full authority and responsibility for the operation of the agency resulted in the poor oversight of the patients diabetic (patients #1 and #14) and medication management and placed all other patients at risk for unsafe and poor quality healthcare.	G 128		
G 133	484.14 (c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on clinical record review, home visits, review of the On Call Log, review of Policies and Procedures, the identification of repeat deficiencies, review of the agency's Performance Improvement Committee minutes, and interviews, the Administrator failed to effectively oversee the	G 133	**G 133 Administrator (Standard)** The DPS in each branch provides day to day oversight and management of operations. The Administrator is responsible to ensure the POC is implemented and will report her findings to the VP of Operations/Governing Board. VP of Operations is ultimately responsible to ensure the ACFs are appropriately staffed and operating in accordance to the all Federal and State regulations governing home care and corrective actions. Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 11 operation and management of the agency. The failure of the Administrator to effectively manage the services provided by the agency resulted in poor diabetic management for patients #1 and #14, poor medication management for the special needs patients with secondary diagnoses involving mental health, the mentally retarded. and/or the developmentally disabled that preclude their independence in the activities of daily living which are serviced by this agency, and places all patients at risk for unsafe and poor quality care. The findings include: The Administrator failed to: Investigate the failure of the agency to provide a nursing visit to Patient #1 on a weekend and the agency's telephone instruction to an unlicensed and untrained employee of the Adult Care Facility (ACF) Ensure the supervision of Skilled Nursing services Ensure that Skilled Nursing Services were provided in accordance with the patient Plan of Care Ensure that the agency nursing staff coordinate care with the physician, the ACF staff, and other staff involved in the patient's care Ensure that the nursing staff reported changes to the physician and revised the patient Plan of Care to meet the patient needs	G 133		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 12 Ensure that the patient Plan of Care was complete and addressed all patient needs Ensure that patients received medications and treatments in accordance with their Plans of Care Ensure supervision of home health aide services Ensure the patient's access to the Patient Rights Protect patient confidentially while providing care to the patients in the ACF Ensure the provision of care in accordance with the agency's Policies and Procedures Ensure the implementation of the corrective action plan for the Statement of Deficiencies issued for the Complaint Survey of 06/04/07. Refer G101, G121, G138, G145, G158, G159, G168, G173, G176, G229. and G236 of this report.	G 133		
G 138	484.14 (d)SUPERVISING PHYSICIAN OR REGIS. NURSE The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse). This STANDARD is not met as evidenced by: Based on clinical record review, home visits (HV), review of agency Policies/Procedures, review of the On Call Lo, review of the agency's Performance Improvement Committee Meeting	G 138	**G 138 Supervising Physician or Registered Nurse** Americare Supervisory staff will make weekly visits to the ACF's to ensure services are rendered in accordance to the POT. The Supervisor will alert the DPS of their findings. Americare DPS is responsible to develop and review the nursing schedule (a month in advance) to ensure services are being rendered in accordance to the Patient's Plan of Care. The DPS develops an in-service and ensures appropriate education is given to the field nurses based on the Supervisor findings. The DPS will report the findings to the Administrator/Governing Authority on a weekly basis and to the Professional Advisory Committee/Board quarterly. Diabetic Educator will conduct bi-weekly case conferences on all insulin dependent patients with Supervisor. ACF nurse & MD until patient's condition stabilizes or becomes independent in insulin administration.	Jan. 4, 2008 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 138	Continued From page 13 minutes, and interviews, the agency's Supervising Nurse failed to ensure that the Skilled Nursing services provided to the agency's patients were appropriately supervised. This resulted in poor medication management for the special needs patients with secondary diagnoses involving mental health, the mentally retarded, and/or the developmentally disabled that preclude their independence in the activities of daily living which are serviced by the agency, poor Diabetic management.provided to patients #1 and #14, and places patients at risk for unsafe and poor quality health care. Refer G 158, G159, G168, G173, G176, and G229.	G 138	100 % Clinical record audit will be conducted on all insulin dependent diabetic patients. All non-insulin dependent Diabetic patients charts will be reviewed on a quarterly basis. Results will be reported to the DPS/Adm & the PAB on a quarterly basis. Diabetic Educator will provide Quarterly Diabetic In-services to the ACF staff nurses. VP of Operations is ultimately responsible to ensure the ACF's are appropriately staffed and operating in accordance to the all Federal and State regulations governing home care and corrective actions. Accepted 1/14/08 TN	Feb. 6, 2008 March 31. 2008 Jan. 10, 2008 & Ongoing
G 145	484.14 (g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to provide the physician a complete summary of the care provided to patients. This was evident for six (6) of sixteen (16) clinical records requiring sixty (60) day summaries. (Patients #1, #4,#5,#7. #10, and #14) The agency's failure to provide the physician with a comprehensive sixty (60) day summary places the patients at risk for poor coordination of care. The finding include:	G 145	The Agency will ensure that all patients (100% chart review) of 60- day summaries are complete, timely and reflect the patients true condition. This will be evidenced by the review of all re-certification documentation upon submission to the agency & Supervisor/QI Nurse/DPS sign off on the documentation checklist. (See attachment #10). The Nursing Supervisor/QI Nurse and/or DPS will review, date and initial all 60 day summaries. The nurse(s) will be scheduled to come into the office on a weekly basis to review and update the clinical records as needed based on the findings on the documentation checklist. DPS will develop a calendar and an attendance record. The DPS for each branch have over all responsibility to develop ongoing in-services, staff education and to ensure the ACF nurses are documenting in accordance to the all Federal and State regulations. T/C 1/14/08 @ 10:40 Am Spoke to F. Faye DPS Acting on behalf of Adm. Amended completion date 1/31/08 Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued From page 14 Patient #1 was admitted to the agency on 07/30/04 with diagnoses of Diabetes Mellitus and Schizophrenia. The patient currently receives Skilled Nursing (SN) daily and home health aide (hha) services. The "60 Day Summary/Medical Update" dated 11/08/07 documents that the patient's blood sugar ranged between 116 to 230. The Skilled Nursing visit notes and the Insulin Treatment Log documents that the patients blood sugar ranged between 92 to 392. The summary failed to document the patient's monthly weight and that the patient was receiving hha services as ordered. On 11/26/07 at 2:30 PM, the administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. On 11/27/07, the administrative staff could not provide any explanation. Patient #10 was admitted to the agency on 09/19/07 with diagnoses of Cellulitis of the Legs, Congestive Heart Failure, Dementia, Diabetes Mellitus Type II, and Depressive Disorder. The "60 Day Summary/Medical Update" signed and dated by the nurse on 11/16/07 lacked documentation of patient's wound status, and blood sugar levels. The 60 Day Summary also documented that the patient has no peripheral edema. However, the nursing visit notes from 9/20 – 10/24/07 consistently documented that the patient has right lower leg edema of "2+".	G 145		TN

STATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued From page 15 During an interview with the Nursing Supervisor on 11/27/07 at 1:15 PM, the Nursing Supervisor was unable to provide an explanation. Patient #7 was admitted to the agency on 05/19/07 with diagnoses of Diabetes Mellitus Type II, Schizoaffective Disorder, and Hypertension. The "60 Day Summary/Medical Update" dated 11/14/07 lacked documentation of the patient's blood sugar levels despite daily nursing visits to perform this tasks. During an interview with the Director of Patient Services (DPS) of Westbury on 11/27/07 at 1:30 PM, the DPS was unable to provide an explanation. Patient #14 was admitted to the agency on 05/10/07 with diagnoses of Psychosis and Diabetes Mellitus. The Record lacked documentation of a "60 Day Summary/Medical Update" for the certification period of 09/07 – 11/05/07. The finding was reviewed with the Nursing Supervisor on 11/27/07 at 11:00 AM and no explanation for the agency's failure to complete and submit the 60 Day summary was provided. Patient #5 was admitted to the agency on 10/04/05 with the diagnoses including Diabetes Mellitus Type II and Hypertension. The Plan of Care dated 09/24 –11/22/07 ordered the SN once a week to perform fingerstick and vital signs every Monday.	G 145		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued From page 16 The "60 Day Summary/Medical Update" for the period of 09/24/07 – 11/22/07 lacked documentation of the range of the patient's vital signs and fingerstick test results. During an interview on 11/26/07 at 3:00 PM the Administrative staff were informed of the survey findings. The Administrative staff was unable to provide an explanation. Patient #4 was admitted to the agency on 10/06/06 with the diagnosis of Diabetes Mellitus Type II The Plan of Care dated 08/02 – 09/30/07 ordered the SN daily to perform fingerstick blood sugar readings and administer Insulin. The "60 Day Summary/Medical Update" for the period of 08/02 – 09/30 lacked documentation of the range of the fingerstick test results. During an interview on 11/26/07 at 3:00PM, the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. On 11/27/07 the agency provided no explanation.	G 145		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on clinical record review, home visits, review of the agency's Policies/Procedures, review of the agency's Performance Improvement Committee Meeting minutes, and interviews, the	G 156	**Acceptance of Patients, POC, Medical Supervision (Condition)** **Monitoring:** Supervisory staff will make weekly visits to the ACF's to evaluate the actual staff practices. • Are staff members following the policy and procedure as it is written in the manual? • Do the staff members need counseling or training? • Are managers adequately monitoring staff practices? Based on the Supervisory visit findings in-service education will be arranged & provided.	TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 156	Continued From page 17 agency failed to: Develop a complete and comprehensive Plan of Care Provide care in accordance with the Plan of Care Revise the patient's Plan of Care as needed Ensure effective coordination of patient services Provide instruction to the patient and Adult Care Facility staff Adhere to the agency Policies/Procedures Implement the corrective actions for the Statement of Deficiencies for the Complaint Survey of 06/04/07. Findings include: Refer G145, G158, G159, G168, G173, and G176 The cumulative effect of the agency's failure to develop, implement and revise the Plan of Care resulted in poor oversight of patients requiring Diabetic management (Patients #1 HV and #14 HV), poor medication management for the special needs population of patients with secondary diagnoses involving mental health, the mentally retarded, and the developmentally disabled that preclude their independence in the activities of daily living, and places all patients at risk for unsafe and poor quality care with the potential for poor patient outcomes.	G 156	DPS for each branch office will provide oversight and responsible to enforce regulation. Americare CSS Administrator/Governing Body will ensure that Westbury & Suffern: • Develop a complete and comprehensive Plan of Care • Provide care in accordance with the Plan of Care • Revise the patient's Plan of Care as needed • Ensure effective coordination of patient services • Provide instruction to the patient and Adult Care Facility staff • Adhere to the agency Policies/Procedures • Implement the corrective actions for the Statement of Deficiencies for the Complaint Survey of 06/04/07. This will be achieved by performing ongoing Performance Improvement/Quality Assurance clinical record audits on a quarterly basis. Results of these audits will be reported to the QI Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. The Administrator will report her findings to the VP of Operations/Governing Board. VP of Operations is ultimately responsible to ensure the ACF's are appropriately staffed and operating in accordance to the all Federal and State regulations governing home care. Accepted 1/14/08 TW	T/c to P. Fay DPS acting on behalf of Admn 2/6/08
158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158	**G 158 Acceptance of Patients, POC, Medical Supervision (Standard)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 18 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, home visits (HV), Policy/Procedure review, and staff interview, the agency continued to fail to ensure that care was provided in accordance with the Plan of Care in ten (10) of nineteen (19) records reviewed and two (2) of eight (8) home visits. (Patients #1 HV, #3. #5. #6. #8. #9. #10. #11. #14 HV, and #17) The agency's failure to ensure that the patients receive care in accordance with the Plan of Care resulted in poor Diabetic and medication management for patients #1 and #14, has the potential for patients to receive inadequate/inappropriate care, places all agency patients at risk for unsafe and poor quality health care, and the potential for negative patients outcomes. The findings include: Patient #1 (HV) was admitted to the agency on 07/30/04 with diagnoses of Diabetes Mellitus and Schizophrenia. The Plan of Care dated 05/16 – 07/14, 07/15-09/12, 09/13-11/11 and 11/12-01/10/08 documents orders for Skilled Nurse (SN) visits daily to"... Diabetic Regime, S/S (signs and symptoms) of Hypo/hyperglycemia causes and intervention. Foot care/Skin Care. Adm Lantus as ordered Q (every) am. Regular Insulin Coverage in AM & PM.... If B/S (blood sugar) > 250".	G 158	The Plan of Care has been reviewed and amended by evidence of physician interim orders in the patient's clinical record for patient's #1, #3, #5,#6, #8,#9, #10, #11, #14, & #17 Feb. 6, 2008 Staff education and in-services will be conducted in both Westbury & Suffern. DPS of each branch is responsible to develop an ongoing staff education/in-service calendar on quarterly basis. Quarterly clinical record audits will be performed by Supervisor/QI nurse/DPS to identify any deficient agency practices. DPS for each branch office will provide oversight and responsible to enforce home care regulations. The DPS will report her findings on a quarterly basis to the **QI committee/ Professional Advisory Board/Committee.** – Americare CSS Administrator will ensure that the required chart audits, education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. This will be achieved by meeting with the DPS on a weekly basis and reviewing ongoing Performance Improvement/Quality Assurance clinical record audit results on a quarterly basis. The Administrator will report her findings to the VP of Operations/Governing Board. VP of Operations is ultimately responsible to ensure the ACFs are appropriately staffed and operating in accordance to the all Federal and State regulations governing home care. T/c 1/14/08 @ 10 40 AM Completion date remains 2/10/08 as per Pat Faye DPS/ acting on behalf of Adm	Jan 10, 2008 & Jan 16, 2008 April 14, 2008 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 19 During the home visit on 11/20/07 at 7:05 AM, the blood sugar log was reviewed. The log documented that the patient tests his blood sugars "twice a day" Interview with the patient during visit, the patient stated that there has been "several days" that the Adult Care Facility staff " drew up the Insulin" for the him and he self administered the Insulin. The Adult Care Facility (ACF) regulations part 487.7 (f) (7) of Title 18 NYCRR (New York Codes, Rules, Regulations) prohibits ACF staff from administering injectable medication. The ACF Standards define the administration of an injectable medication to include the preparation. such as the drawing up and filing the syringe, as part of the administration of an injectable medication. The agency failed to provide SN visits and administer the patient's Insulin as as ordered on the Plan of Care. Refer G176 Patient #14 (HV) was admitted to the agency on 05/10/07 with diagnoses including Diabetes Mellitus, Psychosis, and Hypertenstion. The Plan of Care dated from the start of care to 01/04/08 orders: Skilled Nursing visits daily to administer Lantus Insulin 100 units daily, "diabetic care diabetic regime. S/S (signs and symptoms) of hyper/hypoglycemia:, and included a sliding scale insulin coverage of Humulin R Insulin for blood sugars above 200.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 20 During a home visit on 11/20/07 at 7:00 AM, the blood sugar log (maintained by the patient) was reviewed. The patient stated he tests his blood sugars "three (3) times a day". The log documented seven (7) blood sugar readings above 200 when the patient tested his blood sugars before lunch and ten (10) blood sugars above 200 when the patient tested his blood sugars before dinner from 11/05 – 11/19/07. The patient stated he "did not get any insulin at these times." During interview with the nurse at 7:50 AM, the nurse stated that she was going to "take the information from the log to the Diabetic Consultant and review them with her". The nurse failed to inform the physician of these elevated blood sugars and case conference with the supervisor to ensure that the patient received the insulin coverage as ordered on the plan of Care. During an interview with the Director of Diabetes Education on 11/21/07 at 8:45 AM, the Educator did "not recall" consulting with the nurse about this patient. On 11/27 the agency provided the surveyor with the "Focus Diabetic Chart Audit Tool" dated 11/14/07. The tool was completed by the Educator and documented: ".....Many BS (Blood Sugar) out of range for good control – needs to be reported to the MD". The agency Skilled Nurse, nursing supervisor, and diabetes educator failed to provide diabetic management of the patient in accordance with	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 21 the Plan of Care. Patient #10 was admitted to the agency on 09/19/07 with diagnoses of Cellulitis of the legs, Congestive Heart Failure, Dementia, Diabetes Mellitus Type II, and Depressive Disorder. The Plan of Care dated 09/19 – 11/17/07 orders: Skilled Nursing (SN) two (2) x day sixty (60) to apply Lotrisone to write lower extremity… weigh client weekly times four (4) weeks and then every month… and monitor finger stick blood sugar readings every other week. The clinical record documents a physician order dated 10/09/07 to "apply Lotrisone to groin and rectal area twice a day (BID) for fourteen (14) days, start on 09/22/07 and discontinued on 10/06/07". The nursing visit notes lacked documentation that treatment was rendered according to the Plan of Care and physician's order. The nurse failed to document treatment to the groin and rectal area on visit dates of 09/20 PM, 09/25 AM, 09/25 PM, 09/26 PM, and 10/04/07 PM. On 09/30/07, the nurse visited once to administer wound care treatment. The clinical record lacked documentation that the physician was notified of the agency's failure to provide care in accordance with the Plan of Care. Interview with the Nursing Supervisor on 11/27/07 at 1:30 PM, the supervisor stated that "there has been shortage of nursing and coverage is especially difficult on weekends due to staffing issue."	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 22 Further review of the clinical record lacked assessment of the patient's weight weekly for four (4) weeks and then monthly for visits of 09/19 – 11/06/07 as per the Plan of Care. The patient has a diagnosis of Congestive Heart Failure and is on diuretic treatment of Lasix 20mg PO (by mouth) daily since the start of care of 9/19/07. The visit notes documented that the patient had "persistent peripheral edema 2+ of the lower extremities " and required the increase of the diuretic on 10/03/07 to Lasix 40mg PO daily. The clinical record lacked documentation of the assessment of the patients weight as per the Plan of Care. Interview with the Nursing Supervisor on 11/27/07 at 1:30PM, the Supervisor could provide no further information or explanation. Further review of the clinical record lacked assessment of the patient's blood sugar as per the Plan of Care which ordered the SN to perform fingerstick blood sugar testing every other week (QOW). The clinical record lacked documentation of the fingerstick/blood sugar levels for nursing visit dates of 09/19-10/08/07. The patient is on oral glycemic agent of Avandia 4mg PO daily since start of care of 09/19/07. Interview with the Nursing Supervisor on 11/27/07 at 1:30PM, the Supervisor could provide no further information or explanation. Upon submission of the certified record to the Central Islip DOH office on 12/06/07, the agency provided Supplemental Documentation of a "Diabetic Flow Sheet" listing fingerstick levels for the months of 8/07 –11/07. This flow sheet is maintained in the ACF and was not available at	G 158		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 23 time of survey. A telephone call was placed to the agency on 12/17/07 at 10 AM and 12:45 PM to request a copy of the agency Policy/Procedure on the use of the logs/flow sheets by agency staff which are left in the ACF. The DPS returned the call on 12/17/07 at 1PM and stated she would look the policy and call back. The agency faxed the agency's Adult Care Facility Diabetes Patient Care Plan of Protocol which was not dated to the Central Islip office on 12/17/07. The Protocol documents on page 2 "Nurses or patient/caregiver will complete the Monthly Blood Sugar Montoring Log with available blood sugars and submit a copy each month for the patients record." Patient #3 was admitted to the agency on 02/16/07 with diagnoses of Coronary Atherosclerosis, Congestive Heart Failure, Lower Leg injury, and Hypertension. The Plan of Care dated 10/14 – 12/12/07 orders: Skilled Nursing, 2 Day 60 (twice daily for 60 days) to administer wound care to left leg and home health aide (HHA) services were ordered five (5) days per week x two (2) hours a day x nine (9) weeks. The clinical record lacked documentation of Skilled Nursing visits on 10/14 – 10/19 AM and PM visits, 10/20 AM visit, 10/22-10/23 AM visits. 10/24 – 10/29 AM and PM visits, 10/30 – 10/31 PM Visits. 11/02 and 11/04 PM visits, and 11/10 AM visit. The clinical record also lacked aide activity sheets	G 158		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 24 From 10/11-10/22/07. On 11/27/07 the Director of Patient Services was unable to provide documentation for the missed visits. The clinical record lacked documentation of an explanation for the missed SN visits, lack HHA service from 10/11-10/22/07, and documentation that the physician was notified of the agency's failure to provide care in accordance with the Plan of Care. Upon submission of the certified record to the Central Islip on 12/06/07, the visit notes for 10/28 PM, 11/04 AM, 11/10 PM, and 11/15/07 AM were submitted in a supplemental folder. (Refer G236). Patient #6 was admitted to the agency on 03/31/05 with diagnoses including Schizophrenia, Diabetes Mellitus, and Chronic Airway Obstruction. The Plans of Care dated 09/17/07 – 01/14/08 documents orders for the nurse to monitor the patient's weight monthly and "....symptom management hydration/nutrition status". The nurse's visit notes lacked documentation of a weight for the patient in October 2007. The nurse documented on 10/31/07 that "thin lady appears to be wasting away....." During interview on 11/27/07 at 11:30 AM with the Nursing Supervisor on the case, the supervisor stated that the weight for October was "probably 113 pounds" which was noted in the Progress Note dated 11/08/07.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	1227/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 25 It should be noted that this was a six (6) pound weight loss and that the nursing visits consistently documented that the visits to this patient were 10 -15 minutes in duration. (Refer G176) Patient #17 was admitted to the agency on 10/18/07 with the diagnoses of Open Wound of the Lower Extremity and Organic Brain Syndrome. The Plan of Care dated 10/18-12/16/07 orders: Skilled Nursing Visits to perform Normal Saline Wet to Dry dressings twice a day. The clinical record lacked documentation of wound care provided on 11/10/07 either in the AM or PM. (11/10/07 was a Saturday.) The "Missed Visit Report" dated 11/18/07 documents that a visit was missed on 11/18/07 due to "staff unavailable". The report lacks documentation if the AM, PM, or both visits were missed. The findings were reviewed on 11/27/07 at 11:30 AM with the DPS of Westbury, the DPS of Brooklyn who was appointed by the parent agency to deal with Department of Health issues, and the Nursing Supervisor and no explanation or additional information was provided. Patient #9 was admitted to the agency on 09/05/07 with the diagnoses of Mental Retardation and Hypertension. The Plans of Care dated from the start of care orders: Home Health Aide (HHA) services and included the order for the HHA to weigh the	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page26 patient monthly. The "Aide Plan of Care" dated 09/05/07 documents directions for the HHA to weigh the patient. The HHA activity sheets dated 09/13 – 10/27/07 lacked documented evidence that the HHA weighed the patient as per the Plan of Care. The findings was reviewed on 11/27/07 at 11:00 AM with the DPS of Westbury and the DPS of Brooklyn, the DPS of Westbury stated that the "nurses usually weighs the patient and the Plan of care needed to be reviewed with the physician". Patient #8 was admitted to the agency on 10/18/07 with diagnoses including Diabetes Mellitus, Long Term Use of Insulin, Chronic Airway Obstruction, Schizophrenia and Hypertension. The Plans of Care dated 10/18-12/26/07 orders: Home Health Aide (HHA) services five (5) days a week x one (1) hour a day for assist /supervise personal care, Activities of Daily Living, ensure safety and hygiene and report any status changes to Registered Nurse (RN). From 10/18 – 10/31/07, the clinical record lacked documentation of the patient receiving HHA services. On 11/26/07 at 2:30PM, the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation . On 11/27/07, the Nursing Supervisor could not provide an explanation for the delay of HHA services. Patient #11 was admitted to the agency with	G 158		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 27 diagnoses including Schizophrenia, Diabetes Mellitus Type II, and Hypertension. The Plans of Care dated 08/15-10/13/07 and 10/14 –12/12/07 orders: Skilled Nursing every other week to assess weight monthly, and assess medication regime, and supervise the aide every two (2) weeks. The clinical record lacked documentation that the SN monitored the patient's weight form 08/07 – 11/05/07. the SN visit notes consistently documented the patient had 3 + edema of the lower extremities, yet the SN failed to weigh the patient during the visits as per the Plan of Care. During interview with the Nursing Supervisor on 11/27/07 at approximately 1:40 PM. the Nursing Supervisor acknowledged the findings. Patient #5 was admitted to the agency on 10/04/05 with the diagnoses including Diabetes Mellitus Type II and Hypertension. The Plan of Care dated 09/24-11/22/07 ordered The SN to weigh the client every month and report to MD ten (10) lbs (pounds) weight gain or loss. On 09/19/07, the SN visit note documented the patient's weight as 207 pounds. On 11/05/07, the SN visit note documented the patient's weight as 207 pounds. The record lacked documentation of the patient's	G 158		TN

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 28 weight for the month of October 2007. The record lacked documentation to explain why the nurse did not weigh the patient as per the Plan of Care. During interview on 11/26/07 at 2:10 PM with the Nursing Supervisor and the DPS, the agency's staff provided no further information or explanation.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency continued to fail to develop a complete and comprehensive Plan of Care for all patients. This was evident for eight (8) of nineteen (19) records reviewed and one (1) of eight (8) home visits (HV). (Patients #2, #4, #6 , #7, #10, #14, HV, #16, and #18). This is a repeat deficiency from the complaint survey of 06/04/07. The agency's continued failure to develop a complete and comprehensive Plan of Care places the patients at risk for not having their needs met	G 159	**G 159 Plan of Care (Standard)** **Monitoring:** Supervisory staff will make weekly visits to the ACFs to evaluate the actual staff practices, and to ensure the POT is being adhered to and changes are noted timely. The Supervisor is responsible to review and initial the POT/re-cert for completeness. Based on the Supervisory visit/review findings in-service education will be arranged & provided. Nurses will be required to come into the office as needed to update clinical records. **Systemic Change Initial POT's/Re-Certs Process:** The **Westbury office** has developed a POT/485 worksheet (See attachment # 19) to be completed by the ACF RN, the ACF RN submits the completed worksheet to the Supervisor Assistant. The Supervisor Assistant data enters the information into the computer, prints a copy and the designated Nursing Supervisor for that ACF nurse, reviews, clarifies and approves (initials) the POC/485. If revisions are needed the ACF nurse is contacted and comes into the office to make the needed corrections. Once the Supervisor approves she will print a copy and initial it. The copy is then given to the Supervisor Assistant for mailing. In the **Suffern Office** the ACF nurse data enters the information into the computer. The designated Nursing Supervisor for that ACF nurse, reviews, clarifies and approves the POC/485 via computer. If revisions are needed the ACF nurse is contacted and makes the needed corrections within the computer. Once the Supervisor approves she will print a copy and initial it. The copy is then given to the Supervisor Assistant for mailing.	TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB - UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 29 and possible negative patient outcomes. The findings include: Patient #14 (HV) was admitted to the agency on 05/17/07 with diagnoses including Diabetes Mellitus and Psychosis. The Plans of Care dated from the start of care to 01/04/08 lacked blood sugar parameters for this patient who tests his blood sugars three (3) times a day. The findings were reviewed with the agency Director of Patient Services (DPS) on 11/27/07 at 11:00AM. The DPS acknowledged that an interim order for parameters was not obtained until 11/15/07. During the home visit on 11/20/07 at 7 AM, the patient's blood sugar log documented sixteen (16) blood sugar reading over 200 for the two (2) afternoon testing from 11/05-11/19/07 with no documentation of follow up. The Plan of Care also lacked an order stating that the patient tests his blood sugars three (3) times a day. (Refer G173 and G176) Patient #18 was admitted to the agency on 10/25/07 with diagnoses of Cellilitus and Depressive Disorder. The Plan of Care dated 10/25-12/23/07 ordered the Skilled Nurse (SN) to supervise the Home Health Aide (HHA) every two (2) weeks. The Plan of Care lacked specific orders for the Home Health Aide service to be provided. On 11/26/07 at 2:30 PM, the administrative staff	G 159	**Responsible Person:** DPS for each branch office will provide oversight and responsible to enforce regulation. DPS will report to the Administrator/Governing Body on a weekly basis. Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. The Administrator will report her findings to the VP of Operations/Governing Board. Accepted 1/14/08 TW	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 30 were informed of the survey findings. On 11/27/07 the agency provided a Physician Supplemental Order dated 11/24/07 for certification period 10/25-12/23/07, which documented "Please note omission of HHA (Home Health Aide) services on 10/25/07 485. Pt (patient) with HHA services as of SOC 10/25-7D x 2H x 9 weeks to assist with personal, ADL (Activities of Daily Living) care". The order also included medications which were left out from the 485 dated 10/25-12/23/07 which were Multivitamins with Minerals. Aspirin, Lidocaine, Folic Acid. Thymine HCA. Keflex and Regranex Ointment. Patient #6 was admitted to the agency on 03/31/05 with diagnoses of Schizophrenia, Diabetes Mellitus, and Chronic Airway Obstruction. The Plan of Care dated 11/16/07-01/14/08 ordered "SN every other week to..... finger stick every other week". The Plan of Care lacked any parameters of the blood sugars to ensure physician notification. The Plans of Care contain conflicting information regarding the patient's diet. The Nutritional Requirements are documented as NCS (No Concentrated Sweets) yet the SN tasks document A "ADA 1800 calorie diet." The findings were reviewed with the DPS of Westbury, the DPS of Brooklyn who was appointed by the parent agency to deal with Department of Health issues, and the supervisors on 11/27/07 at 11:15 AM. No explanation was	G 159		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 31 Provided for the incomplete Plan of Care. Patient #10 was admitted to the agency on 9/19/07 with diagnoses of Cellitus of the Legs, Congestive Heart Failure, Dementia, Diabetes Mellitus Type II, and Depressive Disorder. The Plans of Care (POC) dated 09/19-11/17/07 and 11/18/07 –01/15/08 lacked blood pressure parameters although the patient is on the antihypertensive medications of Toprol, Vasotec, and a diuretic of Lasix. During interview with the Nursing Supervisor on 11/27/07 at 1:15PM, the Supervisor could not provide any information or explanation. Patient #16 was admitted to the agency on 06/09/07 with the diagnoses including Glaucoma and Schizoaffective. The Plans of Care dated 08/08-10/06/07 and 10/07-12/05/07 ordered the medication "Haldol Decanoate 100mg/ml ampule 200mg Intramuscular; every 4 (four) weeks". The Plans of Care failed to specify the responsible staff person to administer the injectable medication. On 11/26/07 at 2:00PM the Nursing Supervisor, the DPS of Brooklyn and the DPS of Westbury were informed of the findings. The agency's staff were not able to provide information on who was the responsible staff member to administer the injectable medication. On 11/27/07 at 1:30PM, the agency's staff presented to the surveyor a "Progress Note" that	G 159		TD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 32 was signed and dated "11/27/07" by the nurse. The note was faxed to the agency from the Audit Care Facility (ACF) on 11/27/07 at 8:56 AM. The progress note documented, "For the certification period of 08/08/07 – 10/06/07, client received Haldol Decanoate injections from the Dutchess County Mental Health Program Dr. (Doctor) and R.N. (Registered Nurse). They report she has been compliant and tolerates the medication well". Patient #4 was admitted to the agency on 10/06/06 with the diagnosis including Diabetes Mellitus Type II. The Plans of Care dated 08/02-09/30/07 and 10/01-11/29/07 ordered Insulin sliding scale coverage as "Novolin-R/Humulin 10ml vial coverage subcutaneous; daily 180-200 =2units, 201-250=4units, 251-300 = 6units" The " Diabetic Flow Chart" that is retained in the ACF documented from "08/10/07 to 11/19/07" the Insulin sliding scale coverage as "Novolin Reg coverage: 180-200=2units, 201-250=4units, 251-300=6units, 301-350=8units, 351-400= 10units" The additional Insulin coverage for the Blood Sugar test results of 301 to 400 were not included in the Plans of Care. The "Diabetic Flow Chart" forms were faxed to the agency from the ACF on 11/20/07 at 7:47 AM. During an interview on 11/26/07 at 1:30 PM with the Nursing Supervisor and the DPS, the agency's staff could not provide any further	G 159		TD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 33 Information or explanation. On 11/27/07 at 11:15AM. the agency's staff presented to the surveyor "Physician Supplemental Orders" signed and dated by the nurse on 12/28/0? (the date is not clear). effective "12/29/05. The order from was faxed to the agency from the ACF on 11/26/07 at 5:57PM. The second order form signed by the nurse and not dated for the "certification period 10/01/07 to 11/29/07" was faxed to the agency from the ACF on 11/24/07 at 8:11 PM. Both order forms documented the Insulin sliding scale for the Blood Sugar test results from 180 to 400. The agency staff could not provide an explanation for the agency's failure to ensure that the Plans of Care are complete and comprehensive for the Diabetic management of this patient. Patient #2 was admitted to the agency on 11/1/05 with the diagnosis including Diabetes Mellitus Type II. The Plan of Care dated 10/22-12/20/07 ordered "Flarex 0.1% drops susp (suspension) ophthalmic; 2 (two) times daily apply to both eyes BID PRN (twice a day and as needed) for dry eyes". The Plan of Care documents that this is a "new medication for the patient". The Plan of Care failed to specify the amount of drops to be administered to each eye and the responsible person to administer the eye drops.	G 159		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 34 During interview on 11/26/07 at 1:30 PM with the Nursing Supervisor and the DPS, the agency's staff acknowledged the survey findings. On 11/27/07 at 11:15AM the agency staff presented "Supplemental Physician Orders" signed and dated by the nurse on "11/26/07". The order form was faxed to the agency from the ACF on 11/27/07 at 10:19 AM. The order form documents "effective dates of service: 10/22/07, certification period: 10/22/07 to 12/20/07" and under the section titled as "other: Clarification on Flarex .1% ophthalmic GTT (drops), Pt (patient) is self –administering Flarex 1% 1 (one) gtt to both eyes BID (twice a day) for dry eyes". The agency's staff could not provide an explanation for the agency's failure to ensure that the Plan of Care is complete and comprehensive regarding the patient's eye drops administration. Patient #7 was admitted to the agency on 05/19/07 with a diagnoses of Diabetes Mellitus Type II, Schizoaffective Disorder, and Hypertension. The Plans of Care dated 09/16-11/14/07 and 11/15/07-01/13/08 documents orders for: Skilled Nursing for fingerstick blood sugar testing and to administer Insulin. The Plan of Care lacked on order for blood sugar parameters for dates of service 09/16/07-01/13/08. During an interview with the Director of Patient	G 159		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 35 Services (DPS) on 11/27/07 at 9:30 AM. the DPS provided the surveyor with a "Physician Supplemental Orders" dated 11/27/07 which indicates an omission of fingerstick parameters on the 485 and blood sugar parameters of <60> 400 (less than 60 greater than 400), to notify physician.	G 159		
G165	484.18 (c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on clinical record review, home visits, review of the agency's Policies/Procedures and staff interview, the agency failed to ensure that medications and treatments were provided as ordered in eleven (11) of eighteen (18) records reviewed and six (6) of eight (8) home visits (HV). (Patients #1HV, #3HV, #4HV, #5HV, #6, #10, #13. #14HV, #16, #17HV, and #19) The agency's failure to provide medication and treatments as ordered by the physician resulted in missed visits/Insulin doses and poor Diabetic management for Patients #1 HV and #14 HV and places all patients at risk for poor quality care and the potential for poor patient outcomes. Findings include: Refer G156, G158, G159, G168, G173, and G176.	G165	**G 165 Conformance with Physicians Orders (Standard)** **Staff Education:** All Nursing staff will be in-serviced regarding the Plan of Correction Statement of Deficiencies & Action Plan. Westbury Jan. 10, 2008 & Suffern Jan. 16. 2008. **Monitoring:** Americare CSS Supervising Staff will be visiting all the Adult Care facilities on a weekly basis. The purpose of these visits is to ensure that services, medication and treatments are being rendered in accordance to the patient's POT. The Supervisory staff will provide onsite over site of nursing and home health aide staff, clarify patient issues. problem-solve and case conference patients as required. **System to measure effectiveness:** 1. On a monthly basis Americare CSS will obtain a copy of the POT/485 & Adult Care Facility medication administration record (MAR) for all active patients (inclusive of patients #1,#3,#4, #5,#6, #10, #13, #14, #16, #17 & #19). 2. The nurses will check the MAR against the ACF administration record on weekly basis for changes to medication regime via consultation with ACF staff.	TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 165		G 165	3. On a monthly basis the Americare Supervisors/QI will check the ACF MAR against the MD orders (485). and the Medication Profile in the clinical record. This will be evidenced by documentation from MAR/485/Medication Profile audit tool. (See attachment # 13). Changes will be verified with the MD as evidenced by an interim order. 4. Americare Supervisory staff will provide weekly oversight of the Americare nurses to ensure that medication. and treatments are rendered in accordance to the POT and changes are timely noted evidence by interim orders. 5. The Supervisor/QI/DPS will be conduct clinical record audits on a quarterly basis to ensure that deficient practices do not continue. Results of these audits will be reported to the Professional Advisory Committee/Board Administrator/Governing Body on a quarterly basis. **Responsible Person:** DPS for each branch office will provide oversight and responsible to enforce regulation. DPS will report to the Administrator/Governing Body on a weekly basis. Americare CSS Administrator/Governing Body will ensure that the required Accepted 1/14/08 TN	
G168	484.30 SKILLED NURSING SERVICES	G 168	**Governing Authority involvement/oversight to ensure the agency's compliance:** DPS for each branch office will provide oversight and responsible to enforce regulation. 1. DPS will report tracking & trending results to the Administrator/Governing Body on a weekly basis. 2. Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices.	TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 168	Skilled Nursing Services Continued From page 36 This CONDITION is not met as evidenced by: Based on record review, review of agency Policies/Procedures, home visits (HV), and staff interviews, the agency's Skilled Nurse (SN) failed to: Ensure that the patient has access to information on the Patient Rights Protect patient confidentiality Provide patient services in accordance with patient Plans of Care Ensure development and revision of patient Plans of Care as necessary Ensure effective coordination of patient services Provide instruction education to patient/Adult Care Facility (ACF) staff Submit SN visit notes Provide effective case management and Diabetic Educator consultation Adequately assess patient conditions and notify the physician of changes in the patient needs and condition Adhere to agency Policies and Procedures This was evident for eighteen (18) of nineteen (19) clinical records reviewed and five (5) of eight (8) home visits. The findings include:	G 168	3. The Administrator has ultimate responsibility to ensure that Westbury & Suffern: • Develop a complete and comprehensive Plan of Care • Provide care in accordance with the Plan of Care • Revise the patient's Plan of Care as needed • Ensure effective coordination of patient services • Provide instruction to the patient and Adult Care Facility staff • Adhere to the agency Policies/Procedures • Implement the corrective actions for the Statement of Deficiencies for the Complaint Survey of 06/04/07. 4. This will be achieved by performing ongoing Performance Improvement/Quality Assurance clinical record audits on a quarterly basis. Results of these audits will be reported to the **QI Director/ QI Committee/ Professional Advisory Board** 5. Americare CSS Administrator will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. The Administrator will report her findings to the VP of Operations/Governing Board. • Westbury Jan 10, 2008 & ongoing as needed • Suffern Jan 16, 2008 & ongoing as needed VP of Operations is ultimately responsible to ensure the ACF's are appropriately staffed and operating in accordance to the all Federal and State regulations governing home care. Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

Continued From page 37
Refer G101. G121. G145. G158. G159, G173. G176. G229, and G236 for examples.

The cumulative effect of the failure of the nursing staff to provide appropriate nursing care to the special needs population of patients with secondary diagnoses involving mental health. the mentally retarded. and/or the developmentally disabled that preclude their independence in the activities of daily living serviced by the agency resulted in missed visits/Insulin administration and poor oversight of patients requiring Diabetic management (Patients #1 HV and #14 HV). poor management of medications for these patients unable to manage their medication regime, and places all agency patients at risk for unsafe and poor quality nursing care with potential for poor patient outcomes.

173 484.30 (a) DUTIES OF THE REGISTERED NURSE
The registered nurse initiates the plan of care and necessary revisions.

This STANDARD is not met as evidenced by:
Based on clinical record review, home visit (HV). and staff interviews. the agency nursing staff failed to ensure that the initial patient Plans of Care were initiated and revised as needed. This was evident for fourteen (14) of nineteen (19) records reviewed and six (6) of eight (8) home visits. (Patients #1 HV. #2, #3 HV, #4 HV. #5 HV. #6. #7, #9, #10, #11, #13, #14 HV. #16. and #17 HV)

The agency's failure to ensure that the nursing staff initiated the patient Plans of Care and revised the Plans of Care as needed to meet the

To ensure that <u>all patients</u> (not limited to patients identified on the statement of deficiency) are receiving appropriate care and services the Nursing Supervisor's will make weekly visits to the manors to ensure the ACF nurses:

- Developing a complete and comprehensive Plan of Care
- Provide care in accordance with the Plan of Care
- Revise the patient's Plan of Care as needed
- Ensure effective coordination of patient services
- Provide instruction to the patient and Adult Care Facility staff
- Adhere to the agency Policies/Procedures

The Supervisor s will submit weekly reports to alert the DPS of their findings. Americare DPS is responsible to develop and review the nursing schedule (a month in advance) to ensure services are being rendered in accordance to the Patient's Plan of Care. The DPS develops an in-service calendar and ensures appropriate education is given to the field nurses based on the Supervisor findings.

<u>The DPS is responsible for oversight and will report the findings to the Administrator/Governing Authority on a weekly basis and to the Professional Advisory Committee/Board quarterly.</u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 38 patient needs places all agency patients at risk for substandard care and poor patient outcomes. The findings include: Patient #1 (HV) was admitted to the agency on 07/30/04 with diagnoses of Diabetes Mellitus and Schizophrenia. The Plan of Care dated 05/16-07/14, 07/15-09/12, 09/13 – 11/11 and 11/12 – 01/10/08 documented orders for Skilled Nurse (SN) visits daily to ".....Diabetic Regime, S/S (signs and symptoms) of Hypo/hyperglycemia causes and intervention, Foot care/Skin Care. Adm Lantus as ordered Q (every) am. Regular Insulin Coverage in AM & PM.... If B/S (blood sugar) > 250." During the home visit on 11/20/07 at 7:05 AM, the blood sugar log was reviewed. The log documented that the patient tests his blood sugars "twice a day". During a interview with the patient during home visit, the patient stated that there has been "several days" that the Adult Care Facility staff " drew up the Insulin" for the patient and he self administered the Insulin. During the visit, the patient was observed preparing the Lantus Insulin injection with much instructions from the Skilled Nurse. The blood sugar log and patient record documented the following: On 07/18/07 the staff from ACF drew up the Insulin and the patient self administered.	G 173	To prevent deficient practices from reoccurring ongoing Performance Improvement/Quality Assurance clinical record audits will be done by the Supervisor/QI Nurse/DPS on a quarterly basis. Results of these audits will be reported to the QI Director/ QI Committee/ Professional Advisory Board/Committee. - April 14, 2008 Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued From page 39 On 07/29/07 the record documented "missed visit: (no staff). It is unclear whether the patient received the Lantus Insulin or if coverage was needed. The record lacked documentation of a Blood Glucose reading. On 08/02/07 the Blood Sugar was documented as "172" at 4:10 PM and "patient self administered with staff assistance". On 08/05/07 the Blood Sugar was documented as "269" and "patient self administered with staff " from ACF. The physician order documented that the patient is to receive Regular Insulin coverage if the blood sugar is above 250. The record did not include documentation that the patient received the Regular Insulin as per the orders. The agency SN/Nursing Supervisor failed to inform the physician of missed visits until two (2) and a half months later when the agency was called by the Department of Health regarding a patient care issue. The agency failed to ensure that there is a system in place to meet the diabetic care needs of this Insulin Dependent patient. During interview on 11/19/07 at 8:50 AM with the Nursing Supervisor on call on 08/05/07: the Supervisor stated that there was "no nurse available to visit the patient" and "there is a shortage of nurses". The Supervisor further stated that she called the Adult Care Facility (ACF) and "talked " and employee of the ACF "through drawing up the Insulin and the patient administered the Insulin". The Supervisor stated the ACF employee has "never been taught or observed drawing up Insulin" and this (ACF staff administering Insulin) has 'occurred two (2) other times" but was "not the agency's practice".	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 40 On 11/26/07 at 3:20 PM, a telephone interview was conducted with the evening supervisor of the ACF staff/Medication technician. The ACF staff stated that on 08/05/07, "the nurse from Americare called while the patient was testing his blood sugar and said the "she could not be there because there was some sort of emergency". The ACF staff further stated that she "has not been observed/taught by the Americare nurse on drawing up Insulin" and " her parents were both Diabetic and Insulin dependent so she knows how to draw up the Insulin". The ACF Staff stated that she "held the Insulin bottle for the patient and he drew up the Insulin and self administered in his abdomen". During an interview with the Director of Patient Services (DPS) of Westbury on 11/27/07 at 9:45 AM, the DPS stated that she and the Nursing Supervisor were aware that there was a potential for a staffing problem on the weekend of 08/04 and 08/05/07. The DPS stated she was "on vacation that weekend" and the Nursing Supervisor worked the weekend. The DPS further stated that the agency's policy is that "if a nurse is unavailable to make a visit, the supervisor would make the visit. " The DPS stated that " the Supervisor could only do early morning visits on Sunday and this patient needed his Lantus Insulin in evening." During an interview with the Nursing Supervisor on 11/27/07 at 2:30 PM, the Nursing Supervisor stated that "the Nursing Supervisors have make visits sometimes during the week and on weekends due to staffing issue and not enough nurses to cover the cases. "	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 41 There is no documented evidence that the nurse Revised the Plan of Care until 10/12/07 when the agency received a call from the Department of Health. REFER G158 and G176 Patient #14 (HV) was admitted to the agency on 05/10/07 with diagnoses including Diabetes Mellitus, Psychosis, and Hypertension. The Plan of Care dated from the start of care on 01/04/07 ordered SN visits daily to administer Lantus Insulin 100 units daily, "diabetic care diabetic regime, S/S (signs and symptoms) of hyper/hypoglycemia", and included a sliding scale insulin coverage of Humulin R Insulin for blood sugars above 200". During home visit on 11/20/07 the blood sugar log was reviewed.. The patient stated that he tests his blood sugars "three times a day". The blood sugar log documents seven (7) blood sugar reading above 200 when the patient tested his blood sugars before lunch and ten (10) blood sugars before dinner from 11/05 – 11/19/07. The patient stated he "did not get any insulin at these times." During and interview with the nurse at 7:50 AM, the nurse stated that she was "going to take the information from the log to the Diabetic Consultant and review them". There is no documented evidence that the nurse informed the physician of the elevated blood sugars and revise the Plan of Care to address the	G 173		

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 42 patients needs. (Refer G176) During an interview with the Director of Diabetes Education on 11/21/07 at 8:45 AM, the Educator stated that she "did not recall consulting with the nurse about this patient". The "Focused Diabetic Chart Audit Tool" dated 11/14/07 completed by the Diabetes Educator documents: ".....Many BS (Blood Sugar) out of range for good control – needs to be reported to the MD". During the home visit. the patient's medications were reviewed and compared to the Plan of Care and agency Medication Sheet. The following discrepancies were noted: Lantus Insulin 100 units daily was not on the Medication Sheet dated 11/05/07 The Plan of Care ordered "Depakote 500 mg. one (1) tablet. at bedtime". The patient's medication bottle and the agency medication Sheet documented that the patient is to receive "two (2) tablets of Depakote daily". The Plan of Care and the patient's medication bottle documented that the patient is to receive "Glyburide 5mg. 2 tablets daily". The agency Medication Sheet documents that the patient is to receive "5mg daily". During an interview with the nurse on the home visit. the nurse stated the ACF staff" administers the medications" and she was "not sure how often she was required to review the medications." The nurse failed to initiate the Plan of Care and to	G 173		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 43 revise the Plan of Care to reflect the patient's needs. Patient #17 (HV) was admitted to the agency on 10/18/07 with diagnoses including Open Wound of the Lower Leg and Organic Brain Syndrome. During home visit on 11/20/07, the medications on the patients Plan of care, Medication Sheet and the MAR (Medication Administration Record) in the ACF were reviewed. The following medication discrepancies were observed and noted: The Plan of Care and agency medication sheet documents that the patient is to receive "Risperdal 0.5mg twice a day". The Medication Administration Record (MAR) documents that the patient received "Risperdal 0.5 mg at 7:00 AM and 1:00PM and Risperdal 0.5mg 2 tablets at 5:00 PM and at bedtime". The Plan of Care lacked a documented order for Metamucil 1 packet twice a day. The Plan of Care and the agency medication sheet lacked that the patient received "Tylenol Extra Strength 500 mg 2 tablets by mouth twice daily." During the home visit the Nursing Supervisor was informed of the medication discrepancies and stated that "the nurses are required to review the MAR weekly at the ACF." The nurse failed to initiate the Plan of Care and revise the Plan of Care to reflect the changes in the medications.	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 44 Patient #5 (HV) was admitted to the agency on 10/04/05 with the diagnosis including Diabetes Mellitus Type II. The Plan of Care dated 09/24 to 11/22/07 documents: "Enalapril Maleate 5mg one 1 tablet oral daily." The Medication Administration (MAR) dated September. October and November 2007 documents that the patient was receiving "Enalapril Maleate 2.5mg 1 (one) tablet oral daily". During the home visit on 11/26/07 at 7:00 AM, at the Adult Care Facility (ACF) with the Director of Patient Services (DPS), the MAR was reviewed. After being informed of the medication discrepancies, the agency's staff stated that "when there are changes to the patient's medication regime, the ACF's staff usually faxes a copy of the physician's order and/or inform the nurses regarding the changes." The DPS stated that "the nurses are to review the Plan of Care and the MAR to ensure that the ordered medications are consistent with the Plan of Care." The DPS could not provide an explanation for the nurses and the Nursing Supervisor's failure to ensure that the Plan of Care has been reviewed and revised according to the patient's needs. Patient #4 (HV) was admitted to the agency on 10/06/07 with the diagnosis including Diabetes Mellitus Type II. The Plan of Care dated 10/01-11/29/07 documents: "Seroquel 100mg 2 (two) tablets oral	G 173		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 45 Every AM and PM and Colace 100mg capsule 2 (two) oral QHS (at bed time)". The Medication Administration Record dated September, October and November 2007 documents that the patient was receiving "Seroquel 200mg 1(one) tablet in the morning and 2 (two) tablets at bedtime" and "Colace100mg (1) one capsule orally at bedtime". A home visit was made on 11/26/07 at 7:00AM, at the Adult Care Facility (ACF) with the Director of Patient Services (DPS). The MAR was reviewed. After being informed of the medication discrepancies, the agency's staff stated that "when there are changes to the patient's medication regime, the ACF's staff usually faxes a copy of the physician's order and/or inform the nurses regarding the changes." The DPS stated that "the nurses are to review the Plan of Care and the MAR on a weekly basis to ensure that the ordered medications are consistent with the Plan of Care." The DPS could not provide an explanation for the nurses and the nursing supervisor's failure to Ensure that the Plan of Care has been reviewed and revised according to the patient's needs. Patient #3 (HV) was admitted to the agency on 02/16/07 with diagnoses of Coronary Atherosclerosis, Congestive Heart Failure, and Lower Leg Injury. The clinical record lacked documentation that the nurse revised the Plan of Care to include the patient's current medication regimen. The Plan of Care dated 10/14 – 12/12/07 lacked orders for Ferrous Sulfate 325mg po (orally) daily,	G 173		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued from page 46 Multivitamin 1 tab po daily, Xalatan .005% 1 drop At bedtime. These medications are listed on the Medication Administration Record as being "administered daily" by the staff of the ACF for the months 9/07, 10/07 and 11/07. The Plan of Care dated 10/14-12/12/07 Documents the patient is on "Cipro 500mg 1 tab 2 times daily." During the home visit on 11/20/07 at 11:00AM, the patient stated that he is "not taking Cipro." The ACF's Medication Administration Record documents that Cipro was "discontinued on 05/02/07." The Plan of Care was not revised to reflect this change. The Plan of Care dated 10/14-12/12/07 lacked an order for Xalatan .005% 1 drop to left eye at bedtime. The MAR documents the patient has been receiving the "Xalatan eye drops for the months of 9/07, 10/07, and 11/07." The nursing visit notes for the month 11/07 document the administration of Xalatan eye drops. During interview with the Director of Patient Services (DPS) on 11/27/07, the DPS was unable to provide an explanation for the findings. Patient #10 was admitted to the agency on 9/19/07 with diagnoses of Cellutis of the legs, Congestive Heart Failure, Dementia, Diabetes Mellitus Type 2, and Depressive Disorder. The Plans of Care (POC) dated 9/19-11/17/07	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 47 and 11/18-01/15/08 orders Skilled Nursing for 'assessment of medication regimen". The agency clinical record and the Medication Administration Record (MAR) from the Adult Care Facility (ACF) documents medication discrepancies. The MAR documents: "Omeprazole 20mg 1 tab PO (by mouth) daily" administered 09/21-11/27/07. The agency's clinical record lacked documentation that the nurse revised the Plan of Care to include this medication. On 11/27/07 at 1:15 PM, the Nursing Supervisor was interviewed and was unable to provide an explanation for the noted discrepancies. Patient #13 was admitted to the agency on 08/08/07 with diagnoses of Tear Film Insufficiency, Glaucoma, Depressive Disorder, and an interim order dated 10/22/07 documented new diagnosis of NIDDM(Non-Insulin Dependent Diabetes Mellitus) with an order for Skilled Nursing Visits to perform fingerstick twice a day. The clinical record lacked revision of the Plan of Care to include an order for bloods sugar parameters. The clinical record and the MAR documented that the patient in taking "Micronase/Glyburide 5 mg PO Daily" 11/01-11/11/07. The clinical record lacked documentation that the nurse revised the Plan of Care to include this medication. On 11/27/07 at 1:40 PM, the Supervisor was interviewed and was unable to provide an explanation.	G 173		TN

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 48 Patient #7 was admitted to the agency on 05/19/07 with diagnoses of Diabetes Mellitus Type II, Schizoaffective Disorder, and Hypertension. The Plan of Care dated 09/16-11/014/07 ordered Skilled Nursing three (3) times a day for sixty (60) days for fingerstick and to administer Insulin. The clinical record documents that the Skilled Nurse (SN) visited the patient three (3) times a day until 09/25/07. The record further documents that the SN visited the patient daily from 09/26-11/14/07. The record lacked an ordered to decrease SN from three (3) x a day to once a day. On 11/27/07, the Nursing Supervisor was interviewed and was unable to provide and explanation. Patient #19 was admitted to the agency on 08/16/07 with diagnoses including Diabetes Mellitus, Hypertension and Respiratory Neoplasm. The clinical record documents multiple discrepancies in patient's medications on the current Plan of Care dated 10/15-12/13/07. The Medication Administration Record (MAR) dated November 2007 documents: Aspirin 325 mg po daily was discontinued 08/15/07, Hyzaar 100-12.5 tablet daily, Metforim 850 mg three (3) times a day, Colace 100 mg twice a day, Mirtazepin 7.5 mg at bedtime, Ambien CR 6.25 mg at bedtime, Pamelor 10 mg at bedtime was discontinued 09/13/07, Aggrenox 25-200 mg 1	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 49 capsule daily, Zocor 20mg daily, Norvasc 10 mg daily, and Prilosec 20 mg at bedtime. The Plan of Care documents orders for Aspirin and Pamelor although these medications had been discontinued. The dosage of Hyzaar is documented as "100mg -25mg" although the MAR documented "100-12.5". Included on the POC was "Oxycodone/APAP 5/325 mg tablet two (2) tablets q 4 h". There is no documentation of this medication on the MAR. Aggrenox 25 – 200mg" is documented as every "12 hours". The MAR documents "daily." Metforim is documented as administered daily on the POC. The Medication Administration Record documents "three (3) times a day". "Zocor 20 mg" is ordered to be administered "twice a day." The MAR documents: "daily" administration. "Ambien CR" is ordered to be administered "12.5 mg at bedtime..." The MAR documented that the patient was getting "6.5 mg." "Colace" is ordered to be administered "daily". The MAR documents Colace to be administered " "twice a day." Mirtazepine, Prilosec and Norvasc are included on the POC and not documented on the MAR. The Plan of Care documents: Multivitamin 1 table and Naprosyn 500 mg twice a day prn and	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 50 to be taken with food. There is no documentation on the MAR. The nurse failed failed to review and revise the Plan of Care to reflect the current and accurate medication regime for this special needs patient (Refer G176) Patient #6 was admitted to the agency on 03/31/05 with the diagnoses of Schizophrenia, Diabetes Mellitus, and Chronic Airway Obstruction. The Plan of Care dated 09/17/07 to 01/14/08 orders Skilled Nursing visits "every other week to monitor blood sugars, weights, assess the patient and administer Haldol." The Plan of Care contains conflicting information regarding the patients diet. The Nutritional Requirements are documented as a " NCS (No Concentrated Sweets) "diet. The patient's diet is documented as an "1800 calorie ADA" under the Skilled Nursing tasks. The Skilled Nursing visit notes dated from 07/31 to 11/13/07 documents a fluctuation in patient's weight from 113 to 119 pounds. The Skilled Nursing note dated 10/31/07 does not include documentation of a weight but documents "Thin Lady appears to be "wasting" away says she eats regularly. MD aware". The record lacked any documentation that the nurse spoke to the physician to regarding any follow up to the patients weigh status and/or revision to the Plan of Care to include measures such as supplements.	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 51 The findings were reviewed on 11/27/07 at 11:30 AM with the Nursing Supervisor. The Supervisor stated that when she had a case conference with the nurse on 11/08/07. "the nurse reported patient's weight as 113 pounds" (this was a 6 pound less from the September weight) and the supervisor discussed what measures the nurse should speak to the physician about. The record lacked any revision of the Plan of Care to address the patient's weigh loss. The agency Medication sheets documents discrepancies in the medications ordered on the Plans of Care. For example: The Medication Sheet dated 09/16/07 lacked documentation of the medication. Haldol 75 mg IM which is administered by the nurse every four (4) weeks. The Medication Sheet dated 08/17/07 documents Zyprexa 5 mg BID (twice a day) yet the Plan of Care ordered the medication daily. The Medication sheet also documented Haldol 100 mg yet the Plan of Care ordered 75 mg of the medication. The MAR for the ACF dated 09/01-11/30/07 documents "Zyprexa BID and the Haldo 75 mg." The findings were reviewed on 11/27/07 at 11:00 AM with the Director of Patient Services (DPS) of Westbury. the DPS of Brooklyn who was appointed by the parent agency to deal with Department of Health issues. and the Nursing Supervisor.There was no additional information or explanation provided.	G 173		TD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 52 The nurse failed to review the medications with the physician and revise the Plan of Care as needed. Patient #16 was admitted to the agency on 06/09/07 with the diagnosis including Glaucoma. The Plan of Care date 08/08 – 10/06/07 documents: "Seroquel 200mg tablet orally daily, Seroquel 50mg tablet 2 (two) times daily, Lidoderm 5% (700mg/patch) ADH topical daily Acetaminophen 650mg tablet oral every 4 (four) hours, Desyrel 100mg 2 (two) tablets oral bedtime, Synthroid 75mcg tablet oral bedtime, Toprol XL 100mg tablet SR 24hr oral daily, Ultram 50mg tablet oral 2 (two) times daily and Norvasc 5mg oral daily". The Medication Administration Record (MAR) dated September2007 documents: "Seroquc 200mg tablet oral at bedtime" and in addition to "Seroquel 50mg 1 (one) tablet twice a day, Desyrel 100mg 1 (one) tablet daily at bedtime, Synthroid 0.05mg 1 (one) tablet oral daily and Norvasc 5mg 2 (two) tablets oral daily". The following medications were not included on the MAR: Lipoderm Patch, Acetaminophen, Toprol and Ultram. The Plan of Care dated 10/07-12/05/07 documents: "Seroquel 200mg tablet oral daily, Seroquel 50mg tablet oral 2 (two) times daily, Synthroid 75mcg tablet oral bedtime and Desyrel 100mg tablet 1 (one) tablet bedtime". The MAR dated October 2007 documents that the patient was receiving "Seroquel 200mg 1	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 53 (one) tablet daily bedtime, Synthroid 0.05mg 1 (one) tablet oral daily and Desyrel 100mg 2 (two) tablets oral bedtime". The following medication that was documented on the MAR for October was not included in the Plan of Care of 10/07-12/05/07: Metoprolol 50mg 1 (one) tablet oral daily. The patient record lacked documentation of the physician's order /revision of the Plan of Care and any explanation regarding the changes in the patient's medication regime. During interview on 11/26/07 at 11:40 AM with the Nursing Supervisor and the DPS, the agency staff was unable to provide an explanation. Patient #2 was admitted to the agency on 11/01/05 with the diagnosis including Diabetes Mellitus Type II. The Plan of Care dated 08/23-10/21/07 did not include the ordered medication: "Flarex 0.1% ophthalmic drops 5ml instill 1 (one) drop in both eyes twice a day as needed" The Medication Administration Record (MAR) dated September 2007 documents that the patient was receiving the eye drops per self medication. The Plan of Care lacked revision to include this medication. During interview on 11/26/07 at 11:40 AM with the Nursing Supervisor and the DPS. the agency staff acknowledged the survey findings. Patient #11 was admitted to the agency with diagnoses including Schizophrenia, Diabetes	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 54 Mellitus Type II. and Hypertension The Plan of Care dated 08/15 –10/13/07 and 10/14-12/12/07 orders Skilled Nursing "every other week to assess medication regime." The Clinical record documents medication changes of Mobic 7.5mg discontinued on 9/20/07 and that the patient was started on Mobic 15mg po daily. The Plan of Care dated 10/14-12/12/07 was not revised to reflect these changes. The Medication Administration Record of the ACF documents the patient was started on Mobic 15mg po daily as of 09/20/07. The Plan of Care lacked revision to include this change. On 11/27/07, the agency staff provided the surveyor with a copy of of a " Physician Supplemental Orders" dated 09/20/07 for certification period 08/15/07 – 10/13/07 and an order dated 10/14/07 for certification period 10/14 -12/12/07 correcting the Plan of Care to include Mobic 15mg PO daily. Patient #9 was admitted to the agency on 09/05/07 with diagnoses including Mental Retardation and Hypertension. The Progress Notes dated 10/30 and 11/02/07 documents the need for the patient to receive six (6) days of Home Health Aide services. The nurse failed to revise the Plan of Care to reflect the change in patient needs. (Refer G176) The agency "Medication Procedure/Workflow	G 173		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 173	Continued From page 55 Process" which was undated documents: "1 . On SOC (Start of Care), and at each Recertification and PRN (as needed) the nurse must verify all orders with the MD. 2. If there are changes or discrepancies in the orders, document the changes on the interim/supplemental orders after verifying with the MD. 16. All MAR's (Medication Administration Record) must be reviewed bna dated weekly to validate that you have reviewed all orders with the Med. Tech. Sign and date at bottom of the page." The agency staff failed to follow the agency Policy/Procedure regarding the medication management and review for the special needs population of patients with secondary diagnoses involving mental health. the mentally retarded, and the developmentally disabled that prelude their independence in activities of daily living served by this agency.	G 173		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, inform the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record review, home visits (HV), Policy and Procedure, and staff interviews. the nurses failed to prepare comprehensive notes, coordinate care and inform the physician and other personnel of patient changes in condition	G176	The Nursing Supervising Staff will be visiting all the Adult Care facilities on a weekly basis. The purpose of these visits is to ensure that services, medication and treatments are being rendered in accordance to the patient's POT. The Supervisory staff will provide onsite over site of nursing and home health aide staff, clarify patient issues, problem-solve and case conference patients as required. The Nursing Supervisor's will make weekly visits to the manors to ensure the ACF nurses are preparing clinical and progress notes, coordinating services, informing the physician and other personnel of changes in the patient's condition and needs on a timely basis. The Nursing Supervisor will review the ACF mini record and compare it to the patient's clinical record in the agency. Discrepancies in documentation will be reported to the DPS. The DPS will have the RN come into the office to amend the record with an interim order (contact the physician) or write an addendum. Those nurses that are found to be deficient will be in-serviced and receive a written warning. . The DPS develops an in-service calendar and ensures appropriate education is given to the field nurses based on the Supervisor findings.	TN

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued From page 56 and needs. This was evident for twelve (12) of nineteen (19) records reviewed and four (4) of eight (8) home visits. (Patients #1 H, #2, #6, #8 HV, #9, #10. #13, #14 HV, #16, #17 HV, #18, and #19) The nurse's failure to prepare comprehensive notes, coordinate care and report changes resulted in poor Diabetic management of patients #1 and # 14, poor medication management of the agency's patients, and places all patients at risk for poor quality car and potential for poor outcomes. The findings include: Patient 31 (HV) was admitted to the agency on 07/03/04 with diagnoses of Diabetes Mellitus and Schizophrenia. The Plan of Care dated 05/16-07/14, 07/15-09/12/, 09/13-11/11 and 11/12-01/01/08 documents orders for Skilled Nurse (SN) visits daily to" ...Diabetic Regime. S/S (signs and symptoms) of Hypo/hyperglycemia causes and intervention, Foot car/Skin Care. Adm Lantus as ordered Q (every) am. Regular Insulin Coverage in AM & PM ...if B/S (blood sugar) > 250." During the home visit on 11/20/07 at 7:05 AM, the blood sugar log was reviewed. The log documented that the patient tests his blood sugars "twice a day". During an interview with the patient during visit, the patient stated that there has been "several days" that the Adult Care Facility staff "drew up the Insulin" for the patient and he self administered the Insulin.	G 176	To prevent deficient practices from reoccurring ongoing Performance Improvement/Quality Assurance clinical record audits bill be done by the Supervisor/QI Nurse/DPS on a quarterly basis. Results of these audits will be reported to the **QI Director/ QI Committee/ Professional Advisory Board/Committee.** - April 14, 2008 DPS for each branch office will provide oversight and responsible to enforce regulation. DPS will report to the Administrator/Governing Body on a weekly basis. Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. The Administrator will report her findings to the VP of Operations/Governing Board. Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued From page 57 During the visit, the patient was observed preparing the Lantus Insulin injection with much instructions from the Skilled Nurse. The blood sugar log and patient record documented the following: On 07/18/07 the staff from ACF drew up the Insulin and patient self administered. On 07/29/07 the record documented "missed visit" (nn staff). It is unclear whether the patient received the Lantus Insulin or if coverage was needed. The record lacked documentation if a Blood glucose reading. On 08/02/07 – Blood Sugar was documented as "172 at 4:10 PM – patient self administered with Staff assistance". On 08/05/07 – the Blood sugar was documented as "269"- patient self administered with staff" from ACF. The physician order documents that the patient is to receive regular insulin coverage if the blood sugar is above 250. The record did not include documentation that the patient received the Regular Insulin as per the orders. The agency SN/Nursing Supervisor failed to inform the physician of missed visits until two (2) and half months later when the agency was called by the Department of Health regarding a patient care issue,. The agency failed to ensure that there is a system in place to meet the diabetic care needs of an insulin Dependent patient. During interview on 11/19/07 at 8:50 AM with the Nursing Supervisor on call on 08/05/07, the	G 176		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued from page 58 Supervisor stated that there was "no nurse available to visit the patient" and "there is a shortage of nurses". The Supervisor further stated that she called the Adult Care Facility (ACF) and "talked " and employee of the ACF "through drawing up the Insulin and the patient administered the Insulin". The Supervisor stated the ACF employee had "never been taught or observed drawing up Insulin" and this (ACF staff administering insulin) had "occurred two (2) other times" but was " not the agency's practice". On 11/26/07 at 3:20 PM, a telephone interview was conducted with the evening supervisor of the ACF staff/Medication technician. The ACF staff stated that on 08/05/07. " the nurse from Americare Called while the patient was testing his blood sugar and said that "she could not be there because there was some sort of emergency". The ACF staff further stated that she "has not been observed/taught by the Americare nurse on drawing up Insulin" and "her parents were both Diabetic and Insulin dependent so she knows how to draw up the Insulin". The ACF Staff stated that she "held the Insulin bottle for the patient and he drew up the Insulin and self administered in his abdomen.". During an interview with the Director of Patient Services (DPS) of Westbury on 11/27/07 as 9:45 AM, the DPS stated that she and the Nursing Supervisor were aware that there was a potential for a staffing problem on the weekend of vacation that weekend" and the Nursing Supervisor worked the weekend. The DPS further stated that the agency's policy is that "if a nurse is unavailable to make a visit, the supervisor would make the visit.' The DPS	G 176		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued From page 59 stated that "the Supervisor could only do early morning visits on Sunday and this patient needed his Lantus Insulin in evening. " Record review lacked any coordination with the DPS upon return from vacation. During an interview with the Nursing Supervisor on 11/27/07 at 2:30 PM, the Nursing Supervisor stated that " the Nursing Supervisors have to make visits sometimes during the week and on weekends due to staffing issue and not enough nurses to cover the cases." There is no documented evidence that the nurse revised the Plan of Care until 10/12/07 when the agency received a call from the Department of Health. The record lacked any documentation that the physician was made aware of the agency's failure to provide care in accordance with the Plan of Care and inability to meet the patient's needs until 10/12/07, more that two (2) months later when the agency was called by the Department of Health. The agency's failure to coordinate care and case conference with the physician resulted in the patient self administering Insulin which was prepared by an unlicensed and untrained ACF employee. Patient #14 (HV) was admitted to the agency on 05/10/07 with diagnoses including Diabetes Mellitus and Psychosis. The Plans of Care from the start of care to 01/04/08 orders "Skilled Nursing visits every day to administer Lantus Insulin 100mg" ; Humulin R	G 176		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued From page 60 Insulin coverage for blood sugars over 200. During home visit on 11/20/07. the nurse observed the patient test his blood sugar. The nurse stated she administers the sliding scale Insulin "if the patient's blood sugar is above 200". During the home visit the patient did not require the insulin coverage. During interview with the nurse during the home visit, the nurse stated she "going to take the log to the Diabetic Teacher". The nursing visit notes dated 11/03, 10/30. and 10/29/07 and Progress Notes dated 11/01/07 documents that the patient is " not able to do his own finger stick or insulin administration due to his mental illness." The nursing visit notes and Progress Notes lack documentation that were was any case conferencing with the supervisor and/or physician regarding the patient inability to do finger sticks and the patient's elevated blood sugars. There is no documented evidence that nurse never addressed the need for Insulin coverage or revised the Plan of Care to address these issues. The notes also lack any documentation of follow up with the ACF staff regarding the patient's blood sugar monitoring. The "Focused Diabetic Chart Audit Tool" completed by the Diabetic Educator on 11/14/07 documents the need the blood sugar parameters the lack of coordination regarding the hypo and hyperglycemic readings. the need for teaching of Insulin administration, the need to observe the patient doing the finger stick. the need to report the blood sugars to the physician, and need for lab work.	G 176		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Continued From page 61 As of the home visit (11/20/07) these issues had not been addressed and the nurse had failed to effectively coordinate the diabetic care for this patient. The "Draft" Capillary Blood Glucose Monitoring Protocol documents on page 2:"....Patient's physician's should be informed in cases of mild to moderate patterns of hypo and hyperglycemia". The nurse's failure to coordinate the care for this patient resulted in uncontrolled blood sugars and poor management of this patient's Diabetes. During home visit medication discrepancies were also evident. Refer G173. The nurse failed to provide effective coordination with the physician and the supervisor regarding the patient's medication regime. Patient #17 (HV) was admitted to the agency on 10/18/07 with the diagnoses of Open Wound of the Lower Extremity and Organic Brain Syndrome. The Plan of Care dated 10/18-12/16/07 orders: "SN visits BID (twice a day) to perform dressing change of Normal Saline Wet/Dry....." During home visit on 11/20/07 the nurse was observed removing the dressing and applying a Normal Saline wet to dry dressing. After the change was completed, the surveyor asked the nurse if the wound is to be cleansed with Normal Saline (NS). The nurse stated that she "usually splashes the wound with Normal Saline".	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 62 The agency's undated policy and procedure for Wet to Dry Dressing documents in item #12: ".....Irrigate wound with normal saline or prescribed cleanser". During an interview with the DPS of Brooklyn following the home visit, the DPS stated that "the nurses must follow the physician's order and the physician was using this method was being used to debride the wound." The record lacked any documentation that the physician did not want the wound to be cleansed with NS as per the agency's policy and procedure. The nursing visits notes documented conflicting wound care provided: Nursing visits dated 10/19/07 PM, 10/21/07 AM & PM, 11/1 AM, and 11 AM & PM Documented that the wound was "cleansed with NS"(Normal Saline). During interview with the Nursing Supervisor on 11/27/07 at 11:30 AM, the supervisor stated that "the nurse sometimes splashes the wound to the dressing off because it is painful to remove the dressing". The agency nurse and/or Supervisor failed to coordinate the provision of wound care to ensure that all the nurses provided the ordered and	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 63 correct wound care. Patient #8 (HV) was admitted to the agency on 10/18/07 with diagnoses including Diabetes Mellitus, Long Term use of Insulin, Therapeutic Drug Monitoring. Chronic Airway Obstruction, Schizophrenia, and Hypertension. The Plans of Care dated 10/18-12/15/07 documents orders for: Skilled Nursing, two (2) x a day to monitor Fasting Blood Sugar and administer Regular Insulin. The patient is on sliding scale of Humulin R Insulin coverage for sugars over 251. The Plan of Care dated 10/18/07 documents two (2) sets of sliding scale range for this patient. 1. "Regular Insulin coverage 201-300-4 units; 301 -400-8 units; 401 and greater 12 units. 2. Insulin Regular, Human 100 unit/ml vial (N) Injection 2 times daily 0-250 – 0 units; 251-300 - 4 units; 310-400-8 units; 401 greater – 12 units...." During home visit on 11/20/07 at 10:00 AM, the nurse tested patient's blood sugar. The nurse stated that she administers the sliding scale Insulin "if the patient's blood sugar is above 251 and this morning it's below 251" so "the patient does not require any Insulin coverage today." During the home visit the nurse was interviewed as to how does she know which set or orders to follow. The nurse stated that she "follows the #2 sliding scale Regular Humulin orders because that was on the patient's discharge from the hospital on 10/17/07." During the home visit on 11/20/07, the MAR	G 176		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued from page 64 (Medication Administration Record) at ACF was reviewed and documents that as of 11/09/07 the "Tylenol 325 mg 2 tabs every 4 hours for pain" was discontinued. During interview with the nurse, she stated that she was "not aware of the discontinuation of Tylenol." During the home visit on 11/20/07 at 10:00 AM, the MAR at ACF documents that on 11/09/07 Tylenol 325 mg 2 tab PO every 4 hours for pain was discontinued. The clinical record continued to document on the SN visit notes that the patient was taking Tylenol 500 mg tabs 4 x day PO on 11/15 PM, 11/21 AM, 11/22 AM and PM, and 11/23/07 AM and PM visits. The nurse failed to provide effective coordination with the ACF staff, physician and the Nursing Supervisor regarding the patient's mediation regime. On 11/26/07 at 2:30 PM, the Administrative staff were informed of the survey findings and were given an opportunity provide an explanation. On 11/27/07, no explanation was provided by the agency. Patient #18 was admitted to the agency on 10/25/07 with diagnoses of Cellulitus and Depressive Disorder. The Plan of Care dated 10/25-12/23/07 ordered SN daily x nine (9) days and one (1) every other week for wound care on Right Plantar, cleanse and apply Silvadene cream to area and cover with 2x2/4x4 kling.	G 176		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 65 The Progress noted dated 11/09/07 documents: the "patient was seen at the wound care and the wound care to the Right Plantar remains the same-which is cleanse with Normal Saline, apply Silvadene ointment to dry sterile dressing daily." The note further documents that the physician wants "Aquaphor ointment to patient's shin on legs and around wound daily x fourteen (14) days but the medication may not arrive until Monday 11/12/07." The SN visit notes documents that the nurse visited daily and provided wound care to Right Plantar wound. The visit note of 11/10/07 lacked documentation that the nurse applied Silvadene cream after cleansing the wound with Normal Saline. There is no documented evidence that SN visits from 11/11 to 11/20/07. The Plan of Care dated 10/25-12/23/07 documents multiple medications as follows: Multivitamin with minerals 1 tab daily, Zoloft 50 mg 1 tab daily, Zyprexa 2.5 mg 1 tab daily, Rantidine HCL 75 mg 2 tabs every twelve (12) hours, Zocor 40 mg 1 tab daily, Keflex 500 mg 1 tab 4x daily x 5 days. Probiotic Acidophilus Cap 1 tab daily x 10 days, Aspirin 81 mg 1 tab daily, Buspar 10 mg daily, Folic Acid 1 mg 1 tab daily, Thiamine HCL 100 mg 1 tab daily,Regranex 0 .01 % gel topical; daily to the right instep, Silvadene 1 % cream topical; daily apply to Plantar. It should be noted that theses medications were listed more then once on the 485. On 11/23/07, the Nursing Supervisor wrote a Physician Supplemental Orders for certification	G 176		TN

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 66 period for 10/25-12/23/07 which included medications as follows: Augmentin 8.75 mg twice a day PO (by mouth) discontinued on 11/03/07, Zoloft 50 mg daily PO, Buspar 15 mg PO daily, Zocor 20mg daily PO, Zyprexa 2.5 mg PO daily and Silvadene cream 1 % to Right Plantar daily. On 11/24/07, the Nursing Supervisor wrote additional Physician Supplemental Orders that include orders for additional medications such as Mutivitamins with minerals, Aspirian, Rantidine, Folic Acid, Thiamine HCL, Keflex, and Regranex Ointment. The Medication Administration (MAR) from the ACF dated for October 25 and November 2007 documents that the patient was on the following medications: Augmentin 875 mg twice a day PO (by mouth) discontinued on 11/02/07, Zoloft 50 mg daily PO, Buspar 15 mg daily PO, Zocor 20 mg daily PO, Zyprexa 2.5 mg PO daily. Silvadene cream apply to wound daily by agency RN and Regranex 0.1 ointment apply once a day by agency RN. Further review of the MAR documented that the following medications were discontinued on 10/24/07: Folic Acid, Thiaminic HCL, Aspirin, Ascorbic Acid, Multivitamins, Simvastin 40 mg and Rantidine. The agency SN and/or the Nursing Supervisor failed to review, coordinate and provide effective coordination with the physician regarding the patient's current medication regime. On 11/26/07 at 2:30 PM, the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. On 11/27/07 no further information was provided by the agency.	G 176		TN

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 67 Patient #19 was admitted to the agency on 08/16/07 with diagnoses including Diabetes Mellitus, Hypertension and Respiratory Neoplasm. The clinical record documents multiple discrepancies in patient's medications on the current Plan of Care dated 10/15-12/13/07 and the ACF MAR (Refer to G173). The agency Skilled Nurse failed to review, coordinate with ACF staff, inform Nursing Supervisor and with the physician regarding the patient's current and accurate medication regime. On 11/26/07 at 2:30 PM, the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. On 11/27/07 no clarification was provide by the Administrative staff. Patient #6 was admitted to the agency on 03/31/05 with diagnoses of Schizophrenia, Diabetes Mellitus, and Chronic Airway Obstruction. The Plan of Care dated September 2007 to 01/14/08 orders: Skilled Nursing services every other week to ".....symptom management hydration/nutritional status.... Weigh monthly....Haldol 75 mg injection every 4 weeks.... Finger stick every other week." The Nursing Visit note dated 10/31/07 documents that the nurse observed the patient and noted "Thin lady appears to be "wasting" away....". The note lacked documentation of the patient weight and notification of the physician.	G 176		TN

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 68 There was no documentation of how the nurse knew the physician was aware or if the Plan of Care required revision. There is no documented evidence that the nurse spoke to the HHA who provides care to this patient seven (7) days x two (2) hours a day and is to "Remind patient to go to Dining Room...." as per the Aide's Plan of Care. There is no documentation that the nurse case conferenced with the ACF staff regarding the patient's intake and if there has been any changes. During the nursing visits on 10/03/07, 10/10/07, 10/24/07 and 10/31/07, Haldol was administered on 10/03/07 and finger sticks were done on 10/10 and 10/24/07. The nursing visits were documented as 10-15 minutes in duration. The Progress Note dated 10/31/07 documents a weight of "113 lbs" which was a 6lbs loss from September. The note documents that the Nursing Supervisor "suggested" that the nurse speak to the physician regarding blood tests. The findings were reviewed on 11/27/07 at 11:00 AM with the DPS of Westbury, the DPS of Brooklyn appointed by the parent agency to deal with the Department of Health issues and Nursing Supervisors. No further information was provided. Patient #9 was admitted to the agency on 09/05/07 with diagnoses of Mental Retardation and Hypertension.	G 176		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 69 The Plan of Care dated 11/04/07 – 01/02/08 orders Home Health Aide (HHA) services "5 days x 1 hour" for assistance with activities of daily living and personal care. The sixty (60) day summary dated 10/30/07 documents that the patient receives "6 days x 1 hour" and the Progress Note also dated 10/30/07 and 11/02/07 documents that the patient needs six (6) days of hha service and "Must be prompted & encouraged to participate in personal hygiene". The record lacked documentation of the change in the patient's needs or that the nurse notified the physician of the patient's need for an additional day of HHA services. The finding was reviewed on 11/27/07 at 11:00 AM with the DPS of Westbury, the DPS of Brooklyn, and the Nursing supervisor. No further information was provided. Patient #10 was admitted to the agency on 9/19/07 with diagnoses of Cellulitus of the legs, Congestive Heart Failure, Dementia, Diabetes Mellitus Type II, and Depressive Disorder. The Plan of Care dated 9/19-11/17/07 ordered SN two (2) x day x sixty (60) days to "apply Lotrisone to right lower extremity." The clinical record lacked documentation of coordination of the services for nursing visit times and informing the physician of changes in the nursing visit frequency. The nursing revisit notes document that the nurse visited on 09/22/07 at 3:30 PM - 3:45PM and again at	G 176		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 70 4:00 PM – 5:00 PM. The nursing revisit note dated 9/28 documented a visit from 8:30 AM – 8:50 AM. The record lacked documentation of an afternoon visit. On 9/29 visits were made at 3:00 PM – 3:15 PM and again at 4:00PM – 5:00PM. On 9:30 only one visit was made at 12:00 PM- 12:30 PM. The record lacked documentation that the physician was notified of the missed visits. On 10/06 visits were made at 2:50 PM – 3:10 PM and again at 4:00 PM – 5:00 PM. The nurse failed to coordinate services to ensure treatment to the patient's leg was administered at appropriate intervals to meet the patient's condition and needs. An interview with the DPS from Westbury office on 11/26/07 at 2:30 PM, the DPS stated that the twice a day visits, "the interval for visits should be at least seven (7) hours in between the visits". On 11/26/07 at 3:00 PM the findings were reviewed with the Administrative staff and were given an opportunity to provide and explanation. On 11/27/07 at 1:15 PM, the Nursing Supervisor acknowledged the survey findings. Patient #13 was admitted to the agency on 08/08/07 with diagnoses of Tear Film Insufficiency, Glaucoma, Depressive Disorder, and an interim order dated 10/22/07 documented a new diagnoses of NIDDM (Non-Insulin Dependent Diabetes Mellitus) with an order for SN visits to perform fingerstick twice a day (BID). An interim order lacked parameters for Blood sugars.	G 176		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 71 The nursing visit notes documents elevated FS (fingerstick) on the following visit notes: 10/24/07 -FS=265; 10/25/07 – FS=227; and 11/02/07 – FS=287. The record lacked documentation that the physician as notified of these elevated blood sugar levels. During an interview with the Nursing Supervisor on 11/28/07 at 1:40 PM, the supervisor did not provide an explanation. Patient #16 was admitted to the agency on 06/09/07 with the diagnoses including Glaucoma and Hypertension. The Plans of Care date 08/08 to 10/06/07 and 10/07 to 12/05/07 ordered "SN 2 Day 60 (twice a day for sixty days)" to administer eye drops and to "report B/P (Blood Pressure) <90/60> or >140/90 to MD" and "RN will monitor C/P (cardio pulmonary), C/V (cardio vascular) status". The Plans of Care ordered the antihypertensive medications "Norvasc 5mg oral daily (the medication doses was changed to 10mg on 10/07/07) and Toprol XL 100mg tablet SR 24 hr oral daily". The Skilled Nursing visit notes lack documentation that the Skilled Nurse and/or the Nursing Supervisor notified the physician when the patient's BP readings had exceeded the ordered Blood Pressure parameters (report when blood pressure is more than 140/90). For example: On 08/10/07 – (10:00 AM visit note) the Blood Pressure was documented as 161/83.	G 176		TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 72 08/11/07 – (2:30 PM visit note) BP was documented as 140/96. 08/12 (10:30 AM visit note) BP was documented as 159/89 and (1:30 PM visit note) BP was documented as 183/115. The visit note of 08/13 at 3:25 PM, the note lacked documentation of the patient's vital signs; on 08/16 (8:15 AM visit note) BP was documented as 146/86. On 8/22/07 (3:50 PM visit note) the BP was documented as 156/92 On 8/25/07 (8:25 AM visit note) the BP was documented as 180/79. On 8/26/07 (4:40 PM visit note) the BP was documented as 130/100. On 09/01/07 (2:40 PM visit note) the BP was documented as 163/95. On 09/03 (9:15 AM visit note) lacked documentation of the patient's vital signs. On 09/09 (3:00 PM visit note) the BP was documented as 138/100. On 09/14 (7:15 AM visit note) BP was documented as 160/89. On 09/17 (9:40 AM visit note) BP was documented as 150/87. On 09/20 (2:15 PM visit note) the BP was documented as 157/96.	G 176		

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 73 On 09/21 (9:15 AM visit note) lacked documentation of the patient's vital signs; On 09/23 (10:00 AM visit note) BP was documented as 142/94 and (3:00 PM visit note) BP was documented as 157/107; On 09/25/07 and 09/26/07 (PM visit notes) lacked documentation of the patient's vital signs, On 09/29/07 (9:00 AM visit note) the BP was documented as 159/114. On 09/30/07 (5:00 PM visit note) BP was documented as 149/99. On 10/02/07 (7:45 AM visit note) the BP was documented as 146/90; On 10/05/07 (8:15 AM visit note) the BP was documented as 146/86; On 10/27/07 (6:45 AM visit note) the BP was documented as 157/92; On 10/28/07 (6:30 AM visit note) the BP was documented as 147/91. On 10/31/07 (2:30 PM visit note) BP was documented as 150/97 On 11/01/07 (9:15 AM visit note) BP was documented as 155/88; On 1/02 (8:00 AM visit note) BP was documented as 147/95, On 11/04/07 (9:30 AM visit note) BP was	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 74 documented as 147-90 amd (3:45PM visit note) BP was documented as 154/102. On 11/26/07 at 1:50 PM the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. The Nursing Supervisor stated that the SN should have notified the physician regarding the patient's BP readings. On 11/27/07 at 11:20 AM, the agency's staff presented a note that lacked the title and the agency's name. The note was typed on a regular piece of paper and was faxed to the agency from the Assisted Living Facility on 11/27/07 at 8:44 AM. The note was signed by the nurse and was not dated. The note documented: "On these dates: 8/26/07, 8/22/07, 9/1/07, 9/9/07 pt (patient) had blood pressure as follows: 8/26 –130/100, 8/22-156/92, 9/1-163/95, 9/9 – 138/10. As per physician at Assisted Living Facility, she did not want to be called for any patient on services unless patient was symptomatic and exhibiting symptoms. The Patient was not symptomatic during the dates stated above.:" The Plan of Care dated 11/07 to 12/05/07 and the clinical record lacked documentation of the physician order that documents that the physician did not want to be notified regarding the patient's elevated BP readings. The Plans of Care and the clinical record also lacked documentation that the ordered BP parameters had been revised and/or discontinued. The clinical record lacked documentation of the coordination and management of the patient's cardiovascular status by the SN and the nursing supervisor.	G 176		TW

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 75 The agency staff could not provide an explanation for the SN and/or the nursing supervisor ' failure to notify the physician regarding the patient's BP readings that exceeded the BP parameters as ordered in the Plans of Care. Patient #2 was admitted to the agency on 11/01/05 wotj the diagnosis including Diabetes Mellitus Type II. The Plans of Care dated 08/23 to 10/21/07 and 10/22 to 12/20/07 prdered the "SN 2 Day 60 (twice a day for sixty days) perform FS (finger stick) BID (twice a day), administer Insulin as ordered BID.....". The Plans of Care under the section titled as "Mental Status" documented that the patient is "oriented and forgetful". The SN visit note dated 09/01 (2:15 PM visit) documented that "patient on home leave till 09/04/07". The clinical record and the SN visit notes lacked documentation of the responsible person to perform the twice a day blood sugar monitoring and administration of twice a day Insulin while the patient is on the home leave. The subsequent SN visit notes failed to document how the patient's Diabetic management would be coordinated while on home leave, such as: on 09/13 (PM visit) home visit till 9/15, on 10/12 (PM visit) home visit till 10/15 and on 11/11/07 (AM visit) documented that the patient refused the SN visit. The record lacked documentation that the SN had notified the physician that the patient refused the visit and that the patient did not receive the ordered AM Insulin dose.	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 76 During interview on 11/26/07 at 1:00PM with the Nursing Supervisor and the DPS, the agency staff confirmed the survey findings. On 11/27/07 at 11:00 AM the agency's staff presented : "Progress Note" dated "11/26/07" that was documented by the nurse. The Progress Note was faxed to the agency form the ACF on 11/27/07 at 8:59 AM. The note included an "Addendum to certification period from 10/22-10/20/07, Patient goes on frequent home visits. Americare RN (registered nurse) prefills insulin syringes. Pt (patient) tests FS and administers Insulin with her son supervision and verbal cuing. Pt is unable to independently prefill syringes". The clinical record lacked any documentation of the coordination of the patient's Diabetic status by the SN and the nursing supervisor when the patient was on home visits.	G 176		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d) (1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on clinical record reviews and staff interviews, the agency failed to supervise the Home Health Aides (HHA) no less frequently that every two (2) weeks. This was evident for five (5) of fourteen (14) clinical records of patients receiving Home Health Aide (HHA) services.		Americare CSS Director of Patient Services will ensure HHA Supervision is being done per regulation on all patients receiving HHA services, the RN must observe HHA rendering care every 2 weeks if the case is skilled in accordance to Conditions of Participation. Patients receiving non-skilled personal care services will be supervised every 60 days in accordance to NYS Medicaid Regulations. In-service education regarding the DOH regulation governing HHA supervision was conducted in Westbury Jan 10, 2008 & Suffern on Jan. 16, 2008. A corrective memo to all Adult Care Facility nurses to clarify supervisory regulations. (See attachment # 17). Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 77 (Patients #4, #6, #8, #15, and #18). This is a repeat deficiency from the survey of 6/4/07 The agency's continued failure to supervise the hha every two (2) weeks places the patients at risk for receiving poor quality care. The findings include: Patient #6 was admitted to the agency on 03/31/07 with diagnoses of Schizophrenia, Diabetes Mellitus, and Chronic Airway Obstruction. The Plan of Care dated September 2007 to present orders: HHA services seven (7) days x two (2) hours a day. The clinical record lacked documentation of HHA supervision between 09/13 – 10/09 and 10/11 – 11/12/07. The finding was reviewed with my agency staff on 11/27/07 at 11:00 AM and no explanation or additional information was provided. Patient # 15 was admitted to the agency on 07/30/07 with the diagnosis including Schizoaffective. The Plans of Care dated 07/30 – 09/27/07 and 09/28 – 11/26/07 orders: HHA five (5) days a week x one (1) hour a day for nine (9) weeks to assist/direct the patient with activities of daily living. The clinical record lacked documentation that the	G 229	Americare CSS Supervisors will make weekly supervisory visits to all the Adult Care Facilities to ensure that skilled nursing services are provided to the agency's patients and to ensure HHA supervision is being done per regulation. The Supervisory staff will provide onsite over site of nursing and home health aide staff. The Agency's System Analyst/Operations Manager developed and will update an HHA Supervision Tracking calendar by ACF on all patient's receiving HHA services. The System Analyst/Operations Manager will run a weekly report (every Wednesday) of un-submitted HHA supervisory visit notes by Adult Care Facility Nurse. The ACF nurse will be contacted and asked to fax the HHA supervisory note into the office. Chronic offenders will be required to come to office on a weekly basis to hand in their HHA supervision notes. Chronic offenders will also receive re-education and a written disciplinary warning. If non-compliance continues further disciplinary actions will be taken **The DPS is responsible to ensure that 100% clinical chart audits are done on a quarterly basis to ensure HHA supervision is being done per regulation. (See attachment # 18 HHA Supervisory Audit Tool)** Accepted 1/14/08 TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 78 Skilled Nurse (SN) performed Home Health Aide supervision from 10/03 – 10/29/07. On 11/26/07 at 2:00 PM the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. On 11/27/07, the agency acknowledged the findings and could not provide an explanation why the SN failed to supervise the hha every two (2) weeks. Patient #4 was admitted to the agency on 10/06/07 with the diagnosis including Diabetes Mellitus Type II. The Plan of Care dated 08/20- 09/30/07 ordered HHA seven (7) days two (2) hours a day for nine (9) weeks to assist the patient with personal care. The clinical record lacked documentation that the SN had performed Home Health Aide supervision from 08/24 – 09/19/07. During an interview on 11/26/07 at 2:00 PM with the Nursing Supervisor and the DPS from Westbury, and the DPS of Brooklyn who was appointed by the parent agency to deal with department of Health issues, the agency staff did not provide an explanation for the survey findings. Patient #8 was admitted to the agency on 10/18/07 with diagnoses including Diabetes Mellitus, Chronic Airway Obstructive, Hypertension, and Goiter. The Plan of Care dated 10/18 – 12/16/07 ordered HHA five (5) days a week x one (1) hours a day for nine (9) weeks to assist the patient with personal care, ADLs. Ensure safety and hygiene.	G 229		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 79 The record documentation that the HHA was placed on the case on 11/01/07. The record lacked documentation of HHA supervision from 11/01 – 11/27/07. During an interview the with the Nursing Supervisor on 11/27/07 at 11:45 AM, the Nursing Supervisor could not provide an explanation for the lack of bi monthly HHA supervision. Patient #18 was admitted to the agency on 10/25/07 with diagnosis of Cellulitis and Depressive Disorder. The Plan of Care dated 10/25 – 12/23/07 ordered SN services for wound care and HHA supervision. The record lacked specific orders for HHA services (Refer G159) yet the record included duty sheets for HHA services on the following days: 10/27 – 10/28, 11/03 – 11/04 and 11/10 – 11/11/07. The record documented that the HHA was placed on this case on 10/27/07. The record lacked documentation of HHA supervision from 10/27 – 11/27/07. On 11/26/07 at 2:30PM, the Administrative staff were informed of the survey findings and were given an opportunity to provide an explanation. On 11/27/07, the agency provided a Physician Supplemental Orders dated 11/24/07 (which was after the survey was in progress) for certification period dated 10/25 – 12/23/07 "Please note omission of HHA services 10/25/07 485; Pt	G 229		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	12/272007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 80 (Patient) with HHA services as of SOC (Start of Care) 10/25 7D x 2H x9 weeks assist with Personal. ADL care". During an interview with the Nursing Supervisor on 11/27/07 at 11:45 AM, the Nursing Supervisor stated that she "picked up the omission of HHA services during record review." The Nursing Supervisor could not provide an explanation for the SN failure to supervise the hha every two (2) weeks as per the Plan of Care.	G 229		
G 236	REPEAT DEFICIENCY FROM 06/04/07 SURVEY 484.48 CLINICAL RECORDS A clinical record containing pertinent past and Current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information: name of physician; drug. dietary. treatment, and activity orders; signed and dated clinical and progress notes: copies of summary reports sent to the attending physician: and a discharge summary. This STANDARD is not met as evidenced by: Based on clinical record reviews, Policy/Procedure review. and staff interviews, the agency failed to ensure that the clinical records were complete ad current. This was evident for (8) of nineteen (19) clinical records reviewed. (Patients #1, #3. #5. #7. #8, #13. #16. and #18) The agency's failure to ensure that the clinical records are maintained complete and current places the patients at risk for not having their care	G 236	The Director of Patient Services for both Westbury & Suffern offices is responsible to ensure that **all Patient Clinical Records** contain pertinent past and current findings in accordance to accepted professional standards is maintained for **every active patient receiving home care services**. In addition to the plan of care, the record contains appropriate identifying information; name of the physician; drug. dietary, treatment. and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician: and a discharge summary. The RN in the Adult Facility is responsible to obtain Physician Orders and develop the initial and subsequent Plan of Care (485) in conjunction with the patient and the patient's primary physician. The Supervisor Assistant will check every new Plan of Care (485) for completion by: • Checking the current 485 and all interim orders generated within the 60- day period against the original Plan of Care 485 generated at the SOC and/or the previous 485 for any discrepancies • If discrepancies are present. the Supervisor Assistant will immediately notify the primary nurse and Nursing Supervisor of the findings. • The primary nurse and/or the Nursing Supervisor will make the required corrections and verify the orders with the primary MD. • The Supervisor Assistant will print the Plan of Care (485) for or the nurse to obtain the primary physicians signature.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 81 documented to ensure that quality care is provided. The findings are: Patient #16 was admitted to the agency on 06/09/07 with the diagnosis including Glaucoma. The Plan of Care dated 08/08-10/06/07 documented the medications "Toprol XL 100mg tab SR 24hr oral; daily" and "Liproderm 5 % (700mg patch) ADH. Patch topical daily." The Plan of Care dated 10/07-12/05/07 did not include the above noted medications. The clinical record lacked documentation of the reason for the medications omission on the following Plan of Care dated 10/07 – 12/05/07. The record did not include a documentation of the physician's order to discontinue the medications. On 11/26/07 at 1:20 Pm. The Administrative staff were informed of the survey findings and were unable to provide and explanation. On 11/27/07 at 11:30 AM. the Nursing Supervisor presented to the surveyor 'Physician Supplemental Orders" signed and dated by the nurse on 8/28/07. The order was faxed to the agency form the Adult Care Facility (ACF) on 11/27/07 at 9:18 AM. The orders documemted "certification period 8/8/07 – 10/06/07. effective dates of service 8/28/07. medication change: D/C (discontinue) Toprol XL 100 mg P.O. (by mouth) q.d.(daily) Lipoderm 5% topical patch q.d." The agency's staff could not provide an	G 236	The Americare CSS Supervisors will make weekly supervisory visits to all the Adult Care Facilities to ensure that skilled nursing services are provided to the agency's patients and to supervise Americare CSS staff. clarify patient issues, problem-solve and case conference patients as required. Americare Supervisory staff will provide weekly oversight of the Americare nurses to ensure that medication and treatment changes are timely noted. Americare CSS System Analyst/Operations Manager will run a weekly report (every Wednesday) of un-submitted clinical visit notes by Adult Care Facility Nurse. The nurse will be contacted and asked to fax the clinical note into the office. Chronic offenders will be reported to the DPS and will be required to come to office on a weekly basis to hand in their clinical notes. Chronic offenders will also receive re-education and a written disciplinary warning. If non-compliance continues further disciplinary actions will be taken by the DPS. To prevent deficient practices from reoccurring ongoing Performance Improvement/Quality Assurance 100 % clinical record audits bill be done by the Supervisor/QI Nurse/DPS on a quarterly basis. Results of these audits will be reported to the **QI Director/ QI Committee/ Professional Advisory Board/Committee. - April 14, 2008 & ongoing** DPS for each branch office will provide oversight and responsible to enforce regulation. DPS will report to the Administrator/Governing Body on a weekly basis. Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. The Administrator will report her findings to the VP of Operations/Governing Board.	TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 82 explanation for the nurses/Nursing Supervisor's failure to ensure that the original "Physician Supplemental Orders" were included in the clinical record until the surveyor requested clarification of the findings. Patient #5 was admitted to the agency on 10/04/05 with the diagnosis including Diabetes Mellitus Type II. The Plan of Care dated 09/24 – 10/22/07 ordered Skilled Nurse (SN) to visit the patient every week for nine (9) weeks. The Skilled Nursing visit notes were reviewed from 09/19-10/01/07 and 10/22-11/12/07. The clinical record lacked documentation of the SN visit notes from 10/02 to 10/21/07. On 11/26/07 at 1:00 PM, the agency's Administrative staff were informed of the survey findings and were unable to provide an explanation. On 11/27/07 at 1:00PM, the agency provided the missed SN visit notes dated 10/08, 10/15 and 10/22/07. The agency's staff could not provide an explanation for the missing SN visit notes that were not included in the clinical record. Patient #13 was admitted to the agency on 8/08/07 with diagnoses of Tear Film Insufficiency, Glaucoma, and Depressive Disorder. The Plan of Care dated 08/08 – 10/06/07 orders: Physical Therapy (PT) once a week x nine (9) weeks to maintain strength, ROM (Range of	G 236	T/C 1/14/08 10 40 AM Pat Faye DPS Acting on behalf of Adm All regs including G236 were addressed at previously included Inservice dates TN TN	

"ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 83 Motion), functional & mobility skills. The clinical record lacked Physical Therapy notes for the month of September 2007. On 11/27/07 at 10:001AM, the Nursing Supervisor provided the surveyor with PT notes for 9/19, 9/27 and 10/4/07. There were no PT notes were provided for the week of 09/04 and 09/11/07. On 11/27/07 at 1:40 Pm, the Nursing Supervisor was interviewed and could not provide an explanation for the missed visit notes and notes for two (2) months prior not being included in the clinical record. Patient #1 was admitted to the agency on 07/30/04 with diagnoses of Diabetes Mellitus and Schizophrenia. The Plans of Care dated 05/16 –01/01/08 documents orders for Skilled Nursing daily to administer Insulin. There is no documented evidence of Skilled Nursing visits for the follwing days: 07/18/07. 07/29/07. 08/02/07, 10/17/07, 10/19/07 (AM), and 11/02/07. On 11/26/07 at 2:30 PM, the Administrative staff were informed of the survey findings and were provided and opportunity to provide an explanation. On 11/27/07, no explanation was provided by the agency. On 12/06/07 at 1:30Pm, the agency submitted the certified record to the Central Islip office. The agency included a supplemental documents folder which included SN visit note for 10/18/07	G 236		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 84 AM. The agency failed to ensure that all SN visit notes were in the clinical record as per the agency policy and procedure. Patient #8 was admitted to the agency on 10/18/07 with diagnoses including Diabetes Mellitus, Long Term Use on Insulin, Chronic Obstructive Airway and Schizophrenia. The Plans of Care dated 10/17 –12/15/07 ordered SN two (2) x day to Monitor Blood Sugars and administer sliding scale Insulin coverage. The orders also included to administer Albuterol nebulizer treatment 2 x day. The record lacked skilled Nursing visit notes for the following days: 10/23/07 AM, 10/24/07 AM. 11/03/07 AM, 11/04/07 AM & PM . 11/05/07 PM, 11/08/07 AM & PM, and 11/09/07 AM. On 11/26/07 at 2:30 PM, the Administrative staff wereinformed of the survey findings and were provided an opportunity to provide and explanation. On 11/27/07, the agency provided some of the missing visit notes from October 2007 but could not provide an explanation for the remainder of the SN visit notes not being in the clinical record. On 12/06/07 at 1:30PM, the agency submitted the certified record to the Central Islip office. The agency included a supplemental documents folder which included Skilled Nursing visit notes for 10/24/07 AM, 11/03/07 AM. 11/04/07 AM & PM. 11/05/07 PM, 11/08/07 AM & PM, and 11/09/07 AM.	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNITS	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 85 The agency failed to ensure that all SN visit notes were in the clinical record as per the agency policy and procedure Patient #18 was admitted to the agency on 10/25/07 with diagnoses Cellulitus and Depressive Disorder. The plan of Care date 10/25/07-12/23/07 documents orders for SN daily for nine (9) days and one (1) every other week for wound care on Right Plantar and supervision of aide every two (2) weeks. The record lacked orders for Home Health Aide services yet the record included duty sheets for Home Health Aide services on the following days: 10/27 – 10/28, 11/03-11/04 and 11/10-11/11/07. The record documented that the Home Health Aide was placed on this case on 10/27/07. On 11/26/07 at 2:30 Pm, the Administrative staff were informed of the survey findings and were given an opportunity to provide and explanation. On 11/27/07, the agency provide a Physician Supplemental Orrders dated 11/24/07 (which was after the survey was in progress) for certification period dated 10/25-12/23/07: "Please note omission of HHA services 10/25/07 485; Pt (Patient) with HHA services as of SOC (Start of Care) 10/25 7D x 2H x9 weeks to assist with Personal, ADL (Activities of Daily Living) care". During an interview with the Nursing Supervisor on 11/27/07 at 11:45 AM. the Nursing Supervisor was unable to provide and explanation.	G 236		TN

"ATEMENT OF DEFICIENCIES .D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 86 During interview with the Direct of Patient Services (DPS) of Westbury on 11/27/07 at 11:00AM, the DPS stated that "nursing and therapy notes are required to be submitted to the agency with the week." There was no explanation for the agency's failure to have the Physician's Supplemental Order in the clinical record until the agency was informed of the findings. Patient #3 was admitted to the agency on 02/16/07 with a diagnoses of Coronary Atherosclerosis, Congestive Heart Failure, Lower Leg Injury, and Hypertension. The Plan of Care dated 10/14-12/12/07 orders: "Skilled Nursing", 2 Day 60 (twice daily for 60 days) to administer wound care to left leg and Home Health Aide (HHA) services were ordered five (5) days per week x two (2) hours a day x nine (9) weeks. The clinical record lacked documentation of Skilled Nursing visits on 10/14-10/19 AM and PM visits, 10/20 AM visit, 10/22-10/23 AM visits, 10/24 – 10/29 AM and PM visits, 10/30 – 10/31 PM visits, and 11/02 and 11/04/07 PM visits. On 12/06/07 the agency submitted the certified record to the Central Islip office. The agency included a supplemental folder which included SN visit notes for 10/28 PM and 11/04/07 AM/ The agency failed to ensure that SN notes were in the clinical record as per the agency policy and procedure.	G 236		TW

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G236	Continued From page 87 Patient #7 was admitced to the agency on 05/19/07 with a diagnoscs of Diabetes Mellitus Typc 2 Schizoaffecivc disorder, and Hypcrtension. The Plans of Care dated 09/16 –11/14/17 and 11/15/07 – 01/13/08 ordered Skilled Nursing for fingerstick and to administer Insulin. The clinical record did not include documented evidence of and order for blood sugar/fingerstick parameters for 0916/07 – 01/13/08. (Refer G158) On 12/06/07, a certified copy of the clinical record was received at the Central Islip DOH office. Upon review, the record contained a " Physician Supplemental Orders" dated 09/16/07 documenting a correction to 485 of 9/16/07 – 11/14/07 ordering " Novolin Regular sliding scale coverage 0-200 no coverage, 201-250=2 units, 251-300 = 4 units, etc.." These orders remained unsigned by the physician. The medication profile does not reflect an order for Novolin Regular Insulin coverage. The clinical record lacked documentation that the patient is to receive Insulin coverage. This information was not requested from the agency and there is no explanation for this additional information in the clinical record. The agency Policy and Procedure entitled: "Patient Record Maintenance and Access Policy" effective "6/13/97" documents the following under the area titled "Procedures: Medical Record Maintenance and Storage ." ."…..3. All Clinical documentation will be filled into the patient record within 10 days of receipt by the agency."	G236		TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	**900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 236	Continued From page 88 The agency staff could not provide an explanation for the agency's failure to maintain complete clinical records and to follow the agency's Policy and Procedure for Patient Record Maintenance.	G 236		
G 337	484.55 (c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record review, home visits, review of agency Policies/Procedures and staff interview, the agency failed to ensure that the comprehensive assessment included a complete and accurate assessment of the patient medication regime in eleven (11) of nineteen (19) records reviewed and six (6) of eight (8) home visits (HV). (The agency's failure to ensure that the comprehensive assessment included a review of the patient medication regime places all patients at risk for poor patient outcomes. Findings include: Refer G156, G158, G168, G173, and G176	G 337	Americare CSS will ensure that the nursing staff initiates the POC and revises the POC as needed to **meet all active patient needs.** Americare CSS will provide an in-depth in-service to all ACF nurses by January 31, 2008. Americare CSS has reviewed and revised the Patient's Plan of Care with the patient's physician **on all active patients**, including (Patients #1 HV, #3 HV, #4 HV, #5 HV, #6, #10, #11, #14 HV, #16, #17 HV, and #19)as evidenced by written progress notes and interim physician orders in the clinical record. This was done to ensure that the patient is receiving current care, medications and treatment. On a monthly basis Americare CSS will obtain a copy of the Adult Care Facility medication administration record (MAR) **for all active patients**, the nurses will check the MAR against the ACF administration record , 485 and medication profile on weekly basis for changes to medication regime via consultation with ACF staff. Changes will be verified with the MD as evidenced by an interim order. Americare CSS Supervisors will make **weekly supervisory visits to all the Adult Care Facilities** to ensure that the Americare nurses are reviewing medication and treatment orders and ensuring that changes are timely noted.	Feb. 6, 2008 Feb. 6, 2008 TN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	12/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued From page 89			
G 337	484.55 (c) DRUG REGIMEN REVIEW	G 337	Americare CSS supervisors will review 10% of each Adult Care Facility patient records on a monthly basis. Based on the finding's ongoing education will take place and the audit results will be placed in the nurses personnel record to be reflected on their annual performance evaluation. **DPS for each branch office will provide oversight and responsible to enforce regulation and to ensure that deficiencies do not re-occur**. DPS will report to the Administrator/Governing Body on a weekly basis. Americare CSS Administrator/Governing Body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices. The Administrator will report her findings to the VP of Operations/Governing Board Accepted 1/14/08 TN	Feb. 6, 2008

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines
Commissioner

December 27, 2007

Camille Singer
Director of Patient Services
Metrocare Givers, Inc
325 Gold Street, 3rd Floor
Brooklyn, NY 11201

Re: Response to Plan of Corrections
Survey Date: October 24th 2007
License: 9773L001

Dear Ms. Singer:

Please be advised that the plan of correction relating to the recent Article 36, survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verity the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full survey was conducted on 10/24/07 at MetroCare Givers Inc. Six (6) Patient records were reviewed and are identified as Patients #1-#6. Six (6) Personnel Records were reviewed and are identified as Employees #1- #6.	H 000		
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to provide the patients accurate telephone contact information to lodge a complaint with the New York State Department of Health. Failure to provide accurate contact information places patients at risk for not being afforded their right to lodge a complaint with the New York	H 222	Corrective action to be accomplished for those patients found to have been affected by the deficient practice. Immediatley following the October 24, 2007 survery by the New York State Department of Health (NYS DOH), the Director of Patient Services (DPS) contacted the (NYS DOH) to verify the correct information for patients/caregivers who want to voice complaints or recommend changes in policies to the NYS DOH. The information was verified as follows: NYS DOH complaint hotline telephone # (212) 417-5888; available 10am to 4pm on all state business days. The DPS also reviewed the Patient Bill of Rights to ensure it includes accurate contact information for the NYS DOH complaint hotline. See Patient Bill of Rights (enclosure 1). The "Client Manual" has been updated to reflect the correct information to contact the NYS DOH. See page 2-3 Client Manual (enclosure 2) All active clients and clients discharged after the date of the NYS DOH's complaint hotline telephone number change will be mailed a letter of explanation along with a copy of the Bill of Rights and the revisions to the Client Manual. The DPS will call all clients to ensure they received the documents and answer any questions. This contact will be documented in the client's records and will be competed by January 4, 2008. The DPS educated the field staff in the accurate contact information for the NYS DOH complaint hotline (December 18, 2007). The Registered Nurse Field Supervisor (RNFS) will review the patient Bill of Rights and the Client Manual for accurate contact information for the NYS DOH complaint hotline during the client's next scheduled visit. The RNFS will answer any questions the client has regarding the complaint process. To be completed within 3 months (March 20, 2008) 2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. New patient packets will be reviewed by the DPS to ensure they contain accurate NYS DOH complaint hotline contact information. The RNFS will insure accurate NYS DOH complaint hotline contact information is provided to all new admissions by reviewing the Client Manual and the Patient Bill of Rights with all new admissions. Effective immediately and ongoing. 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Camille M. Singer RN — TITLE: 12/20/07 — (X6) DATE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS. INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
H 222	Continued From Page 1 State Department Of Health. The findings are: The agency: " Client Manual" documents the following information on page 2-3: " "Should you not be satisfied with the outcome, you may file your complaint or grievance with the New York State Department of Health, (212) 268-6406. The documented number is not the correct information to contact the New York State Department of Health. The agency " Bill of Patient Rights " documents the following information on page 1, item #11: " Have your complaints heard, reviewed, and if possible resolved and recommend changes in policies and services to the agency staff, the governing authority and the New York State Department of Health (xxx-xxx-xxx) " There is no documented evidence of the current telephone number. On 10/24/07 at 3:50PM, the Director of patient services was interviewed and stated that she was not aware we moved.	H 222	The DPS is responsible to ensure all information in the Patient Bill of Rights and the Client Manual is updated as needed. When an update is indicated the DPS will update the appropriate form (i.e., Bill of Rights or Client Manual, etc.) and archive the out of date form. The DPS will educate the RNFS and establish an implementation date. The RNFS will be responsible to educate the clients to the new information and provide them with updated forms. During the quarter following the implementation date the DPS will conduct an audit to ensure that the accurate information is being provided to the clients. This will occur immediately and ongoing. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. DPS will conduct an audit of 100% of active client roster on a quarterly basis to ensure all records have been updated to include the accurate telephone contact information for clients to lodge a complaint with the NYS DOH. The results of the audit will be reported by the DPS to the Performance Improvement (PI) Committee at the quarterly PI meeting. Effective immediately and ongoing. This information will be reported to the Governing Authority. 5. Responsible Party (s): Director of Patient Services, R.N. Field Supervisor	
H 408	766.3(d) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months;	H 408	1. Corrective action to be accomplished for those patients found to have been affected by the deficient practice. - Patient #5. An RN visit will be performed to assess the patient and the need for PT/OT therapy. - The result of assessment will be phoned to patient's MD for appropriate referrals. 2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All patient records will be reviewed to ensure all ordered services are addressed and reflected in the medical orders assessments and care plans where appropriate. A nursing visit will be performed if the patient record has any discrepancies in what is ordered and what is documented. By Director of Nursing and Field nurse supervisor. (Nov. 15, 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS. INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From Page 2 (1) each review shall be documented in the clinical record; and (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the plan of care reflected all the ordered services that the patient was receiving. This was evident for one 91) out 0f six (6) patient charts reviewed. (Patient #5). Failure to include all ordered services places the patient at risk for poor quality of care. The findings are: Patient #1 has diagnoses which include Seizure Disorder, Osteoporosis and Hypothyroidism. The medical order dated 2/10/06 documents:".... Continue physical therapy in patient ' s home 2 x a week for gait balance, strengthening. Physical Therapy to evaluate again for above on 2/20/06." There is no documented evidence that Physical Therapy was initiated. On 10/24/07 at 4PM, the Director of Patient Services was interviewed and was unable to provide an explanation for the finding.	H 408	What measures will be put in place or what systematic changes will made to ensure that the deficient practice does not recur. - At the times of admission, RN 3 month assessment and RN as needed assessments the RN performing the assessment will review all ordered services and ensure they are reflected and followed-up patients record. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. - The Director of patient services or RN field supervisor will review all charts of newly admitted patients, patients who have had a 3 month or prn assessment one week after the Rn has made the visit to ensure compliance with the above plan of correction. On November 15th, 2007 and ongoing. The results of the audit will be reported by the DPS to the Performance Improvement (PI) Committee at the quarterly PI meeting. and upwards to the Governing Authority.	
H 514	766.4(d) Medical orders 766.4 Medical orders.	H 514	1. Correction action to be accomplished for those patients found to be have been affected by the deficient practice. - Physican of patient #1 will be telephoned and the NYSDOH regulation of thirty day MD signatures will be discussed and reviewed to ascertain ways MD orders can be signed	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS. INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H 514	Continued From Page 3 (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to ensure that medical orders were signed within 30 days. This was evident for one (1) out of six (6) records reviewed. (Patients #1). Failure to ensure that medical orders are signed within 30 days place the patient at risk for poor quality of care. The findings are: Patient #1 has diagnoses which include: Pigmentation Retinitis, History of bilateral Inguinal Hernia, Asthma and Bilateral lower leg Varicosities. The agency: " Home Health Certification and Plan of Treatment " from 5/3/06-11/3/06 was signed by the physician on 6/27/07. On 10/30/07 at 4PM the Director of Patient Services was interviewed and stated " I found that it was not done."	H 514	and returned in a timely manner by 1/10/2008. 2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All patient active records will be reviewed for outstanding MD signatures. All outstanding orders will be faxed to the physician's office with a request for an immediate signing and re-faxing. If there is one week remaining for orders to be signed, an RN will personally visit the phsycians office to obtain the md's signature. By the Director of Patient Services and RN field supervisor. By 1/4/08. 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur. - Starting immediately all physician's office for timely signatures within 30 days. If there is one week remaining for orders to be signed an RN will personally visit the physicians office to obtain the signature after calling to be sure the physician is there. If physician is not in the office at that time an appointment will be made. By Director of patient services and RN field supervisor. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. - The Director of Nursing will formulate a list of MD orders to be signed within 30 days and will review it daily to be sure orders are received and signed in a timely manner. By Director of Patient Servces and RN field supervisor. By December 17th, 2007. The results of this review will be reported by the DPS to the Performance Improvement Committee (PI) at the quarterly PI meeting, and upward to the Governing Authority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 4	H 616		
H 616	766.5(b)(2) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (2) staff are assigned to the care of patients in accordance with their licensure, and their training, orientation, and demonstrated skills. This Rule is not met as evidenced by: Based on record reviews and interview the agency failed to ensure that supervision was provided for employees while the results of the criminal history record check are pending. This was evident for two (2) out of six (6) employee records. (Employees# 1 and #6). Failure to ensure that supervision was provided as required place the patient at risk for unsafe and poor quality of care. The findings are: 1) The personnel record for Employee #1 (Home Health Aide) documents a hire date of "6/5/07". The personnel record documents evidence of a " fingerprint rejection" letter dated 7/10/07 and a " Criminal History Record Check Resubmission Form " dated 7/17/07. There is no documented evidence of weekly supervision from the time of hire to the date of the rejection letter and from the resubmission of the fingerprints to the present date.	H 616	H 616 766.5 (b) (2) Clinical Supervision 1.Corrective action to be accomplished for those employees found to have been affected by the deficient practice. - Bi-weekly RN visits notes and daily telephone call logs for employees 1 & 6 were requested of the RN field supervisor and the staffing coordinator. Bi-weekly RN visit notes and telephone logs are now in the personnel of employees 1 & 6 (copies attached). Policy and Procedure for Criminal History Background checks was reviewed by the OPS and also reviewed and reinforced with RN field supervisor and staffing coordinator. 2.How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -Records of all employees who have not had their criminal history background check will be reviewed by OPS. Any lapses in RN visits or phone calls will be remedied immediately. An RN will schedule the needed visit with the patient for the next day and a telephone will be made by OPS to the patient's home. Effective: Immediately by November 16th, 2007 by RN field supervisor and OPS -All employees with criminal history background checks outstanding will continue to have an RN visit bi-weekly and alternately a telephone call by the staffing coordinator to the patient's home until a disposition is made with the return of their criminal history background check. Effective: Immediately and ongoing by OPS and RN field supervisor. 3.☐What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur. -☐Starting immediately documentation of RN supervisory visits will be submitted weekly to the OPS by field nurse supervisors. RN Field supervisors will be in-serviced on this new procedure by November 16, 2007. If RN supervisory visits are not submitted weekly RN Field Supervisor will be telephoned, Policy & Procedure will be reinforced by the OPS RN will be requested to do supervisory visit immediately. Supervisory note can either be faxed or RN must bring personally to the agency. All faxed notes must have the original submitted to the OPS by the end of the week. Telephone logs will be reviewed by the OPS to satisfy off site observation requirements weekly. If required telephone call to patient's home are found to be lacking, staffing coordinator will have Policy & Procedure reinforced and call will be made to patient's home by OPS. Immediate and on-going by OPS and RN Field Supervisor. 4.☐How the corrective action will be monitored to ensure the deficient practice will not recur. -☐Employee records will be audited weekly to ascertain timely documentation is placed in the employee records. Immediately and ongoing by OPS and field nurse supervisor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H 616	Continued From Page 5 2) The personnel record for Employee #6 (Home Health Aide) documents a hire date of "6/7/07". The personnel record documents evidence of a "fingerprint rejection" letter dated "7/10/07" and a "Criminal History Record Check" resubmission form dated "7/24/07". The personnel record does not include documented evidence of weekly supervision from the time of hire to the date of the rejection letter and from the resubmission of the finger prints to the present date. On 10/24/07 at 4 PM, the Director of Patient Services and the Human Resource Supervisor verified the findings.	H 616	The results of the audit will be reported by the DPS to the performance improvement (PI) Committee. At the quarterly PI meeting. Effective immediately and ongoing. This information will be reported to the governing authority.	
H1036	766.9(I) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (I) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety,	H1036	H1036 766.9(1) Governing Authority Section 766.9 1.Corrective action to be accomplished for area found to have been affected by the deficient practice. -Metrocare Givers has identified the consumer and a back-up consumer (should the consumer not be available to attend a scheduled meeting). to attend all PI meetings. The DPS has discussed attendance and role of the Consumer at Performance Improvement meetings. Vice President's Administrative Assistant will contact the Consumer and back-up Consumer to review the schedule of upcoming meetings and the need of their attendance by November 12, 2007. See sign-in sheet for PI meeting of December 10th, 2007. 2.How the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -The agency will assure the presence of a consumer at all PI meetings hence forth. Two weeks before quarterly PI meeting Vice President's Administrative Assistant will call the Consumer and verify attendance at the meeting. If Consumer cannot attend the back-up Consumer will be immediately contacted. By VP Administrative Assistant monthly and on-going. 3.What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur. -All members of the PI meeting have been provided with a calendar of 2008 PI meetings by VP's Administrative Assistant on January 31st, 2008 and will be contacted one month before the date of the next PI meeting. If Consumer cannot attend the back-up Consumer will be immediately contacted. If back-up Consumer cannot attend PI meeting, the meeting will be re-scheduled by Administrative Assistant to Vice President and DPS. By November 12th 2007 and ongoing. 4.How the corrective action will be monitored to ensure the deficient practice will not recur. -Attendance at Performance Improvement Committee will continue to be monitored for the attendance of the consumer. By the Vice President and DPS. This information will be reported to the Governing Authority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS. INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 6 adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Rule is not met as evidenced by: Based on record reviews and interview, the agency failed to ensure that the Quality Improvement Committee meetings included a consumer, a random record review of patients that are currently receiving services and a review of patients discharged from the agency within the past three (3) months were discussed. Failure to ensure that the Quality Improvement Committee performs the required functions places patients at risk for poor quality services, unsafe and inadequate care. The findings are: The agency " Quality Improvement Committee Meeting " minutes dated "3/28/06, 6/28/06, 9/14/06", does not include documented evidence of a consumer at the meetings. On the cover sheet of the minutes dated "12/19/06, 3/8/07 and 6/27/07", it was documented that the consumer was absent.	H1036	H1036 766.9 (o) Goveming Authority Section 766.9 Governing authority 1.Corrective action to be accomplished for those areas found to have been affected by the deficient practice. -DPS will review policy procedure and practice of quarterly chart reviews. Director of Patient Services (DPS) will review 3 random charts and 1 discharge chart (if applicable for that quarter) each month. Chart review for quarterly last quarter Performance Improvement (PI) meeting are reflected in minutes of December 10th 2007 PI meeting. There were no discharges for the last quarter. 2.How the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -Starting immediately the Director of Patient Services will ensure chart reviews of random patients to ensure quality services, as well as safe and adequate care are incorporated into the minutes of the quarterly PI meetings. All Discharging within the quarter will be reviewed and also be discussed. By DPS and ongoing in 2008. 3.What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. -Going forward in 2008 the minutes of all PI meetings will be monitored for the presence of random chart reviews for both active and discharged patients for quality of services as well as safe and adequate care provision. Quarterly in 2008 by Vice President and DPS. 4.How the corrective action will be monitored to ensure the deficient practice will not recur. -The results of the audit will be reported by the DPS to the Performance Improvement Committee. Effective immediately and ongoing. This information will be reported to the Goveming authority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
H1036	Continued From Page 7 The QI meeting minutes documents statistics for Accidents/Incidents, Patient Complaints/ Grievance Statistics, Plan of Care/ Duty Sheets, Doctors orders, PPD Testing Pain Management, Competency Testing, Quality Indicator (Fall Risk) and patient satisfaction. There is no documented evidence of random patient record review. There is documented evidence of 11 patient discharges from 1/07- 6/07. There is no documented evidence of discussion of these discharges at the 3/8/07 or 6/27/07 meetings. On 10/24/07 at 3:50 PM, the Director of Patient Services was interviewed and stated that they "have not replaced the consumer" and that "after the meetings" the Director of Patient Services and the physician discuss patient records.	H1036		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be	H1142	H1142 76.9 (o) Governing Authority Section 766.9 Governing authority 1.Corrective action to be accomplished for those areas found to have been affected by the deficient practice. - V.P. and DPS reviewed the regulations and agency practice of the Health Provider Network (HPN) in 2006, and a Policy & Procedure was formulated. Attached is a copy of our Policy and Procedure for the Health Provider Network (HPN). This Policy and Procedure was presented at the quarterly meeting 2006 for review and approval. This policy and procedure was also submitted to the Governing Authority that month for review approval. 2. How other areas having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -The DPS will access the Health Provider Network (HPN) by logging on to the official HPN Network to be informed of alerts, Letters To The Administrator, changes and revisions to the Criminal History Background Check Policy's and Procedures, information concerning licensed home care agencies and for communication during emergency situations 24hrs a day / 7 days a week. That would be 10/31/07 and ongoing. To Metrocare Givers will continue to follow our Policy and Procedure for the HPN. Immediate and ongoing. By Vice President and DPS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS. INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 8 created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to develop and policy and procedure for the Health Provider Network (HPN). Failure to develop policy and procedures for the agency ' s HPN account fails to direct the agency staff in how to respond to requests for information by the local health department, management in emergency situations and failed to ensure the maintenance of the agency ' s HPN program.	H1142	3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur. - The Director of Patient Services will access the HPN daily to be informed of alerts, new requirements or changes, by using her password to log on. A log will be developed to record daily access. The DPS will develop and keep the log. The Vice President will review the logs quarterly. Begining 2008 and ongoing. HPN policy will be revised as new or different requirements are identified and will be brought before quarterly Performance Improvement meetings for discretion, review, and implementation as these changes immerge. The Policy and Procedure for the Health Provider Network (HPN) will be reviewed yearly by the Vice President and Director of Patient Service (DPS) and all proposed changes and additions will be discussed at the quarterly Performance Improvement meetings. By December 30, 2007. 4.How the corrective action will be monitored to ensure the deficient practice will not recur. - All revisions or changes to the HPN policy will be brought to the attention of the Quarterly Performance Committee for discussion and implementation. And forward to the Governing Authority for approval. 2008 and ongoing by Vice President and DPS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 9 The finding is: The agency policy and procedure manual did not include documented evidence of a policy and procedure for the Health Provide Network. On 10/24/07 at 3:30 PM, the Director of Patient Services was interviewed and stated that the agency "does not have the HPN policies".	H1142		
H1338	766.11(g) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (g) that personnel records include verifications of employment history and qualifications for the duties assigned and, as appropriate, signed and dated applications for employment; records of professional licenses and registrations; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessment shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given patient medical records under section 766.6 of this Part. This Rule is not met as evidenced by: Based on record reviews and staff interview the agency failed to ensure that all personnel records included verification of employment history. This was evident for two (2) out six (6)	H1338	Page 10 H1338 766.11 (g) Personnel 766.11 Personnel 1. Corrective action to be accomplished for those patients found to have been affected by the deficient practice. - Files of employees 1 and 5 reviewed by DPS and HR Personnel for correct process in obtaining employment verification (see attached). Process was reviewed and reinforced to HR Personnel by DPS. By October 26, 2007. Re-verification of these 2 employees was done on 10/26/07 by Human Resources Personnel. 2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - HR staff will review all current records to ensure correct process for verification of employment is documented in their records. By HR personnel by January 31, 2008. 3. What measures will put in place or what systematic changes will t that the deficient practice does not recur. - A quarterly audit of all new employees will be carried out by DPS and HR personnel to ensure employment verification process is follow-up and reflected in the records. By DPS and HR Personnel in March 2008 and ongoing. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. - The results of the audit will be reported by DPS at the quarterly Performance Improvement Committee. Effective immediately and ongoing. This information will be reported to the governing authority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H1338	Continued From Page 10 records reviewed.(Employees #1, and #5). Failure to ensure that all employment history is verified places the patient at risk for poor quality of care. The findings are: 1) Employee #1 is a Home Health Aide (HHA) hired with a documented hire date of "6/5/07". The personnel record includes (1) agency " Employee Reference Inquiry " form and 1 verified personal reference. The personnel record did not include documented evidence that the employment reference was verified. 2) Employee #5 is a HHA with a documented hire date of "2/29/00". The personnel record included (2) agency " Employee Reference Inquiry " forms. The personnel record did not include documented evidence that the references were verified. On 10/24/07 at 4:15PM the Director of Patient Services and the Human Resources Administrator were interviewed. The Human Resource Supervisor stated that the "reference inquires were faxed and returned faxed".	H1338		
H1354	766.11(l)(1) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (l) (1) that a program is implemented and enforced for the prevention of circumstances which could	H1354	Page 11 H1354 766.11 (1)(1) Personnel 766.11 Personnel 1. Corrective action to be accomplished for those patients found to have been affected by the deficient practice. - Employee number 2 will have infection control training in Standard Precautions/HIV Confidentiality Law. Employee will also sign the HIV letter at the time of her In-service. By DPS or RN Field Nurse supervisor. By 12/31//07. - Employee number 3 has been inserviced on Standard Precautions/HIV Confidentiality Law and has signed the HIV letter. By DPS. Date of inservice 12/17/07. - The DPS accessed the HPN Network. The Minimum Standards for Licensed Home Care Agencies requirements were reviewed for Personnel Records (see attached). As per this regulation all employees will be inserviced on Standard Precautions/HIV Confidentiality Law at orientation and then yearly. At the time of mandatory inservice on Standard Precautions/HIV Confidentiality Law; the HIV letter will be signed by employees and documentation of signing will be placed in their employee record. November 2007 and ongoing.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	9773L001	A. BUILOING _____ B. WING _____	10/24/2007

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
METRO CARE GIVERS. INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLET OATE
H1354	Continued From Page 11 result in an employee or patient/client becoming exposed to significant risk body substances which could put them at significant risk of HIV or other blood-borne pathogen infection during the provision of services, as defined in sections 63.1 and 63.9 of this Title. Such a program shall include: (i) use of scientifically accepted protective barriers during job-related activities which involve, or may involve, exposure to significant risk body substances. Such preventive action shall be taken by the employee with each patient/client and shall constitute an essential element for the prevention of bi-directional spread of HIV or other blood-borne pathogen; (ii) use of scientifically accepted preventive practices during job-related activities which involve the use of contaminated instruments or equipment which may cause puncture injuries; (iii) training at the time of employment and yearly staff development programs on the use of protective equipment, preventive practices, and circumstances which represent a significant risk for all employees whose job-related tasks involve, or may involve, exposure to significant risk body substances; (iv) provision of personal protective equipment for employees which is appropriate to the tasks being performed; (v) a system for monitoring preventive programs to assure compliance and safety. This Rule is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure that all employees receive the required annual training on HIV	H1354	2. How other patients having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All employees who have not had in-service this year 2007 for Standard Precautions/HIV Confidentiality Law, had been scheduled for training to December 2007. At that time HIV Confidentiality will be discussed and employees will sign the HIV Confidentiality letter. Employees. Documentation of signing will be placed in their employee record. By DPS, Field Nurse Supervisor by 12/31/07. 3. What measures will put in place or what systematic changes will be made to ensure that the deficient practice does not recur. - Beginning in January 2008 the HIV Confidentiality letter will be signed at annual Infection Control Training and will be placed in employee files for all professional and para-professional personnel. By DPS and RN Field Nurse Supervisor. - The Director of Patient Services with the aide of HR Personnel will assure that all professional and para-professional personnel are in compliance with yearly mandatory Infection Control Training by checking their in-service status monthly when calendars are formulated. Aides and Nurses may also be called in and trained on one-to-one basis to accommodate their work schedules beginning 2008. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. - DPS will perform a final record audit in December of each year to insure Infection Control Training is documented in all professional and para-professional personnel. The results of this yearly audit will be reported by the DPS to the Performance Improvement Committee at the quarterly PI meeting. Effective 2008 and on-going this information will be reported to the governing authority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9773L001	A. BUILDING _____ B. WING _____	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO CARE GIVERS, INC.	325 GOLD STREET BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	Continued From Page 12 Confidentiality and Universal Precautions. This was evident for two (2) out of six (6) personnel records reviewed. (Employees #2, #3). Failure to ensure that employees receive the required annual in-services places the patients at risk for receiving poor quality care. The findings are: 1) The personnel record for Employee #1(Home Health Aide) documents a hire date of "3/18/03". The personnel record does not include evidence of annual HIV Confidentiality and Universal Precautions training. 2) The personnel record for Employee #2 (Registered Nurse) documents a hire date of " 8/1/05". The personnel record does not include evidence of annual HIV Confidentiality training. The last HIV training in the personnel record is dated "7/15/05". On 10/24/07at 4:30 PM the Director of Patient services was interviewed and stated: "..... in reading the regulations, it was not clear that HIV was required annually however it would be done."	H1354		

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street. New York, NY 10007

Richard F. Daines M. D.
Commissioner

November 1, 2007

Catherine Giandurco
Executive Vice President
Premier Home Health Care Services, Inc
8002 Kew Gardens Rd, Ste 402
Kew Gardens, NY 11415

License: LC0584A
Onsite Visit: June 21, 2007

Dear Ms. Giandurco:

Please be advised that the Plan of Correction relating to the Article 36 survey of your agency has been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417- 5888.

Sincerely,

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospice Services
Metropolitan Area Regional Office

PREMIER
home health care services, inc.

October 25, 2007

Ms. Patricia Jones, RN, MN
Deputy Regional Director
Metropolitan Area Regional Office
New York State Department of Health
90 Church Street
New York, N.Y. 10007

Dear Ms. Jones:

The agency's 8002 Kew Gardens Rd, Kew Gardens N.Y., branch location was audited by the NYSDOH back on 6/21/07 and has received a Statement of Deficiency as a result of the audit.

Enclosed please find the corrective action plan to address the deficiencies documented in the S.O.D.

Please contact me with any questions regarding the enclosure at 914-428-7722.

Most Sincerely,

Catherine Giandurco

Catherine Giandurco
Executive Vice President

RECEIVED
OCT 29 2007
REGIONAL ADMINISTRATION
NYSDOH

360 Hamilton Avenue, Suite 120, White Plains, New York 10601 Phone 914-428-7722 Fax 914-428-2404

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A full survey was conducted at Premier Home Health Care Services, Inc. on June 21, 2007. Two (2) Patient Records were reviewed and are identified as Patients #1 and #2. Five personnel records were reviewed and are identified as employees 1 - 5.	H 000	In an effort to identify other branch offices that may be impacted by this deficiency the agency reviewed all of its NYS licenses and identified 3 additional licenses that list Physical and Occupational therapy as services provided by the branch.	
H 108	765-2.2(c) Amendment of a License 765-2.2 Amendment of a license. (c) After issuance of an initial license, a licensed home care services agency shall notify the department in writing at least 30 days prior to commencing or discontinuing physical therapy, occupational therapy, speech/language pathology, nutrition services, social work, respiratory therapy, physician services, or medical supplies, equipment and appliances. This Rule is not met as evidenced by: Based on review of the agency's license; the agency failed to notify the department in writing at least thirty (30) days prior to discontinuing Physical Therapy and Occupational Therapy services. The agency's failure to ensure that the operating license is current, complete and accurate places all patients at risk for not being aware of care services provided by the agency. The finding is: The agency's operating license documents that	H 108	The agency has corrected this deficiency by submitting a letter to the Metropolitan Area Regional Office of the NYSDOH requesting an amendment to the licenses that list these services. (Please see enclosed letter dated 10/24/07). The agency has **not** provided Physical or Occupational Therapy, nor has it marketed verbally or in its written or electronic materials to its clients, community or contracts, that such services are provided by the agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive VP — (X6) DATE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A full survey was conducted at Premier Home Health Care Services, Inc. on June 21, 2007. Two (2) Patient Records were reviewed and are identified as Patients #1 and #2. Five personnel records were reviewed and are identified as employees 1 - 5.	H 000	After careful evaluation of the impact to patient risk because of these service listings on its license, the agency has no findings to suggest that presence of these service listings has had any negative impact on its clients, service community or contracted vendors. The agency will continue **not** to market or advertise Physical and Occupation Therapy as services it provides as it waits for the amended licenses. The Executive Vice President is responsible for this corrective action. The time frame to complete the request for licensure amendment is 11/2/07.	
H 108	765-2.2(c) Amendment of a License 765-2.2 Amendment of a license. (c) After issuance of an initial license, a licensed home care services agency shall notify the department in writing at least 30 days prior to commencing or discontinuing physical therapy, occupational therapy, speech/language pathology, nutrition services, social work, respiratory therapy, physician services, or medical supplies, equipment and appliances. This Rule is not met as evidenced by: Based on review of the agency's license, the agency failed to notify the department in writing at least thirty (30) days prior to discontinuing Physical Therapy and Occupational Therapy services. The agency's failure to ensure that the operating license is current, complete and accurate places all patients at risk for not being aware of care services provided by the agency. The finding is: The agency's operating license documents that	H 108		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 108	Continued From Page 1 the agency provides " Physical Therapy and Occupational Therapy." During the interview on 6/21/07 with the VP of Regional Operations at 3:30 pm, he stated that the agency does not provide Physical Therapy or Occupational Therapy. He noted that they only provide Home Health Aide and Personal Care Aide from that office.	H 108	In an effort to identify the potential risk for other patients who may not have been provided with the correct Department of Health telephone number to use in the event the client chooses to express a complaint, the agency reviewed 100% of the remaining branch private pay clinical charts. The audit reveled that in 100% of the remaining charts, the correct Department of Health telephone number was present on each client's Patient Bill of rights and therefore the correct number had been provided to all other clients. The client affected by the deficient practice was provided with the correct Department of Health telephone number on an amended Patient bill of rights form and instructed that the number is the contact number to express a complaint regarding the home care services he/she receives from the agency. Documentation of the review of the amended number and its purpose is in the client's clinical chart.	
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal. This Rule is not met as evidenced by: Based on record review and interviews, the agency failed to provide the patients with the correct telephone number for the Department of Health to lodge a complaint. The agency's failure to provide accurate information placed patients at risk for not being afforded their right to lodge a complaint with the Department of Health.	H 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 108	Continued From Page 1 the agency provides " Physical Therapy and Occupational Therapy." During the interview on 6/21/07 with the VP of Regional Operations at 3:30 pm, he stated that the agency does not provide Physical Therapy or Occupational Therapy. He noted that they only provide Home Health Aide and Personal Care Aide from that office.	H 108	All of the agency's Patient Bill of Rights forms were reviewed and found to contain the number 212-417-5888. Additionally, the agency has modified its Patient Bill of Rights Policy, 15.3, to include the State of New York Department of Health Telephone	
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal. This Rule is not met as evidenced by: Based on record review and interviews, the agency failed to provide the patients with the correct telephone number for the Department of Health to lodge a complaint. The agency's failure to provide accurate information placed patients at risk for not being afforded their right to lodge a complaint with the Department of Health.	H 222	number and lists NYSDOH as an additional source a client may choose to express a complaint to regarding the services he/she receives from the agency. (Please see the enclosure) The numbers for the United States Department of Health and JCAHO shall remain in the policy as specified under 766.1(8), clients have a right to voice complaints and recommend changes in policies and services to agency staff, the NYSDOH or any outside representative of the patient's choice. A notice of Policy amendment shall be issued to the agency's branch offices on 11/2//07.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 108	Continued From Page 1 the agency provides " Physical Therapy and Occupational Therapy." During the interview on 6/21/07 with the VP of Regional Operations at 3:30 pm, he stated that the agency does not provide Physical Therapy or Occupational Therapy. He noted that they only provide Home Health Aide and Personal Care Aide from that office.	H 108	An in-service to review the amended policy will be conducted over the next several weeks during Branch Meetings. The completion of the in-service for this policy shall be completed by 12/13/07.	
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal. This Rule is not met as evidenced by: Based on record review and interviews, the agency failed to provide the patients with the correct telephone number for the Department of Health to lodge a complaint. The agency's failure to provide accurate information placed patients at risk for not being afforded their right to lodge a complaint with the Department of Health.	H 222	Further, beginning 11/1/07 and over the next 4 months, a 10% sample of private pay clinical charts will be to audited to monitor and determine on-going compliance with this corrective action plan. At the end of the 4-month period, the agency shall re-evaluate the need to continue with a sample focus audit.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 2 The findings is: The agency's Policy "Patient Bill of Rights 15.3" documented that patients were being directed to lodge complaints to "United States Department of Health Telephone # 1-800-628-5972." The Complaint/Occurrence Involving Patient Services documents "Joint Commission Hotline 800-994-6610." These are not the correct number to lodge complaints. During interview with the VP of Regional Operations on 6/21/07 at 3:33 pm, the VP of Regional Operations stated that the numbers are incorrect and will be changed.	H 222	The Field Nurse Supervisor is responsible for this corrective action plan completed by 12/14/07 and completion of the 4-month focus sample audit will be completed on 2/28//08.	
H1306	766.11(c) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (c) that the health status of all new personnel is assessed and documented prior to assuming patient care duties.The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Rule is not met as evidenced by: The findings are:	H1306	The personnel files for employee's # 1,2,3 and 4 were reviewed and found not to include documentation of statement that the employees are "free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which many alter the individual's behavior. The agency conducts annual random drug screen panel tests on all potential and active employees to screen for depressants, stimulants, narcotics, and other drug substance usage. This practice has been in effect at the agency since 1996 and lab results of such tests are found in each employee's personnel file in the medical section.	

ew York State Department of Health

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
'REMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 2 The findings is: The agency's Policy "Patient Bill of Rights 15.3" documented that patients were being directed to lodge complaints to "United States Department of Health Telephone # 1-800-628-5972." The Complaint/Occurrence Involving Patient Services documents "Joint Commission Hotline 800-994-6610." These are not the correct number to lodge complaints. During interview with the VP of Regional Operations on 6/21/07 at 3:33 pm, the VP of Regional Operations stated that the numbers are incorrect and will be changed.	H 222	The agency's health assessment and physical forms were modified on 5/17/ 07 and 10/24/07 respectively to include the statement "the person is free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior". The Assessment form has been utilized by the agency since June 1/07 and the modified Employee Physical form will be implemented effective 11/1/07.	
H1306	766.11(c) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (c) that the health status of all new personnel is assessed and documented prior to assuming patient care duties.The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Rule is not met as evidenced by: The findings are:	H1306		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1306	Continued From Page 3 Based on record reviews and interviews it was determined that the agency did not obtain health statements for employees. This was evident for 4 of 4 personnel files reviewed for the Freedom of Habituation to Drugs and Alcohol statement. The finding is: The Personnel files for Employees #1, #2, #3 and #4 did not include documentation of statement that the employees are "free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individuals's behavior." During the interview with the VP of Regional Operations on 6/21/07 at 4pm, the VP of Regional Operations stated that the statements are "missing".	H1306	The agency shall perform health assessments on employees 1,2,3 and 4 in advance of their annual schedule by 11/16/07 and for the remaining employees, the agency shall capture the Habituation to Drugs and Alcohol statement at the time of each individual's next routine health assessment. The agency's amended Health Assessment and Employment Physical forms are available on the agency's Forms Directory and the version with out the statement has been removed. Each branch Administrator will review and in-service its staff on the change in the physical form during branch meetings held over the next several weeks. Time frame for completion of this process is 12/14/07.	
H1337	766.11(f)(ii) Personnel Section 766.11 Personnel The governing authority or operator shall ensure for all health care personnel: (f)(ii) a criminal history record check to the extent required by section 400.23 of this Title This Rule is not met as evidenced by: Based on personnel record review and staff interview, it was determined that the agency failed to ensure that a criminal history record check was completed in one (1) of one (1)	H1337		

ew York State Department of Health

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1306	Continued From Page 3 Based on record reviews and interviews it was determined that the agency did not obtain health statements for employees. This was evident for 4 of 4 personnel files reviewed for the Freedom of Habituation to Drugs and Alcohol statement. The finding is: The Personnel files for Employees #1, #2, #3 and #4 did not include documentation of statement that the employees are "free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individuals's behavior." During the interview with the VP of Regional Operations on 6/21/07 at 4pm, the VP of Regional Operations stated that the statements are "missing".	H1306	The branch shall review 10% of its monthly Health Assessments beginning 12/1/07 for a 4-month period to determine on-going compliance with this corrective action plan. The agency shall re-evaluate its need to continue with focus audit at the end of the 4-month period. The time frame for the completion for the sample focus audit is 3/31/08. The Branch Administrator is the person responsible for the correction of this deficiency.	
H1337	766.11(f)(ii) Personnel Section 766.11 Personnel The governing authority or operator shall ensure for all health care personnel: (f)(ii) a criminal history record check to the extent required by section 400.23 of this Title This Rule is not met as evidenced by: Based on personnel record review and staff interview, it was determined that the agency failed to ensure that a criminal history record check was completed in one (1) of one (1)	H1337		

New York State Department of Health

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584A	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	8002 KEW GARDENS RD STE 402 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From Page 4 personnel record reviewed (Employee #4). The findings are: Employee #4 personnel record lacked documentation lacked documentation that a Criminal History Record Check was initiated and completed. During the interview with the VP of Regional Operations on 6/21/07 at 3:55pm, the VP of Regional Operations stated the agency does the "Acufact" and the Federal criminal history check on all employees.	H1337	The agency was cited for Personnel record #4. The SOD states that this record was found to lack documentation that a Criminal History Record Check was initiated and completed on the referenced employee. The aide's Criminal History Record Check was initiated and completed as evidenced by the receipt of confirmation from NYSDOH CHRC division. (Please see the enclosure). The aide's personnel file did not contain a copy of the DOH CHRC 102 form. Subsequently, the agency requested employee #4 to complete a new 102, which has been provided in this POC as an enclosure. Additionally, a sample focus audit of 26 personnel records was conducted by the agency to determine the presence of the 102 forms in each record. The 102 forms were found in 100% of the sample files audited.	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines
Commissioner

Wendy E. Saunders
Chief of Staff

February 25, 2008

Ms. Celestina Tina Cruz, RN
VP of Clinical Services
Premier Home Health Services, Inc
494 8th Ave
New York, NY 10001

Re: Response to Plan of Correction
Survey Date: June 28, 2007
License: LC0585A

Dear Ms. Cruz:

Please be advised that the plan of correction relating to the recent Article 36, survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verity the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

PREMIER
home health care services, inc.

February 22, 2008

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospice Services
Metropolitan Area Regional Office

RE: LHCSA License #1086L005
Date of Survey- 6/28/07

Dear Ms. Phoenix-Tannis:

First, I would like to thank you for the extension you granted our agency on 2/8/08 for completing the Plan of Correction (POC) for this survey.

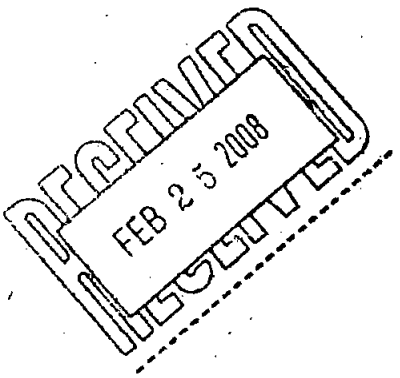
Second, there are two sets of attachments with the POC. They contain documentation in reference to tags H1008 and H1002.

Please feel free to call me at 914-428-7722 if you have any questions or concerns regarding the POC.

Sincerely,

Celestina (Tina) Cruz, RN
VP of Clinical Services

*Sent via fax and Federal Express on 02/22/08



360 Hamilton Avenue, Suite 120, White Plains, New York 10601 Phone 914-428-7722 Fax 914-428-2404

PRINTED: 10/15/2007
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES. INC.	494 8TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full Survey was conducted at Premier Home Health Care Services, Inc., on June 28, 2007. Eight (8) patient care records were reviewed and are identified as Patients #1 - #8. Five (5) personnel records were reviewed and are identified as Employees #1- #5.	H 000		
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal. This Rule is not met as evidenced by: Based on record review and interview,the agency failed to provide patients with the correct telephone number for complaint notification. The agency's failure to provide current and accurate information placed patients at risk for not being afforded their right to lodge a complaint with the Department of Health.	H 222	**H222** As part of the admission process, it is the policy of Premier Home Health Care Service (#15.3) to review the Patient's Bill of Rights Document and obtain the signature of the patient or patient's representative. A copy of the signed Bill of Rights is filed in the patient's clinical record and in addition, a copy is left for the patient. The Bill of Rights lists the complaint hotline phone number for the Department of Health. **I. Corrective action for those patients found to be affected by the deficient practice:** The Statement of Deficiency did not identify which specific patients in the sample were affected by the deficiency. Sample patient #1 was discharged from services. Sample patients #2, #3, #4, #5, #6, #7, and #8 were transferred to another office. Residents #2 and #3 expired and patient #7 was discharged from services. Patients #4, #5, #6, and #8 were readmitted to services when they transferred to the new office. All of the admission paperwork was resigned, including the correct version of the Bill of Rights. Copies of the new, signed Bill of Rights were left in the patients' homes and a copy was placed in their clinical records. Continued next page...	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	VP of Clinical Services	10/30/08

PRINTED: 10/15/2007
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	494 8TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 1 The finding is: The agency's "Patient Bill of Rights" instructs patients of the following: "....to lodge complaints to the State of New York Department of Health at 212-613-4703....." The documented number is not the correct number to lodge a complaint with the department of health. On 6/28/07 at 2:33pm, the Regional Director was interviewed and stated that the number is incorrect.	H 222	**II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** All private pay and case managed patients have the potential to be affected by the deficient practice. All case managed records will be audited by the Office Administrator and Field Nurse Supervisor to determine compliance with the regulation. For the patients found to be out of compliance, the Field Nurse Supervisor will conduct a home visit to review the correct version of the Bill of Rights with the patient, obtain his/her signature or his/her representative's signature and leave a copy at the patient's home for their reference. The FNS will place a copy in the patient's clinical record. Persons responsible: Administrator FNS Regional DPS Date of Correction: 6/25/08 **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** The Field Nurse Supervisors and Per Diem nurses will be directed to immediately remove all unused, incorrect Bill of Rights documents in their possession and in the office. The Administrator, Field Nurse Supervisors and all Per Diem Nurses will be in-serviced on Policy #15.3 by the Regional DPS. Persons responsible: Regional DPS Date of Correction: 6/25/08 Continued next page...	
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on record reviews and interviews, the agency failed to hold meetings of the governing authority responsible for the management and operation of the agency in compliance with State Rules and Regulations. The failure to ensure that the Governing Authority meet and perform the required functions of the governing body, places all patients at risk for poor quality care. The findings is:	H1002		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	494 8TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 1 The finding is: The agency's "Patient Bill of Rights" instructs patients of the following: "....to lodge complaints to the State of New York Department of Health at 212-613-4703....." The documented number is not the correct number to lodge a complaint with the department of health. On 6/28/07 at 2:33pm, the Regional Director was interviewed and stated that the number is incorrect.	H 222	**IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** 25% of the case-managed records will be audited each quarter for a one year period to ensure compliance with the regulation. Parties responsible for the correction and ongoing compliance are: Office Administrator Field Nurse Supervisors Regional DPS Vice President of Clinical Services Date of Correction: 6/25/08	
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on record reviews and interviews; the agency failed to hold meetings of the governing authority responsible for the management and operation of the agency in compliance with State Rules and Regulations. The failure to ensure that the Governing Authority meet and perform the required functions of the governing body, places all patients at risk for poor quality care. The findings is:	H1002	**H1002** The agency's Corporate QI committee includes the agency's C.O.O. and V.P. of Human Resources and Administration, both of whom have board designation as members of the agency's executive committee. The executive committee serves at the pleasure of the board. The following sections of Premier Home Health Care Services Inc.'s Policy and Procedure 5.0, Agency By-Laws, delineate the authority and delegation powers of the Board of Directors. **Section 3- Annual and Regular Meetings' Notice:** (a) A regular annual meeting of the board of Directors shall be held after the close of the fiscal year of the Corporation. Continued next page...	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	494 8TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 1 The finding is: The agency's "Patient Bill of Rights" instructs patients of the following: "...to lodge complaints to the State of New York Department of Health at 212-613-4703....." The documented number is not the correct number to lodge a complaint with the department of health. On 6/28/07 at 2:33pm, the Regional Director was interviewed and stated that the number is incorrect.	H 222	**Section 13- Committees:** The Board of Directors, by resolution adopted by a majority of the entire Board, may from time to time designate from among its members an executive committee and such other committees, and alternate members thereof, as they deem desirable, each consisting of two or more members, with such powers and authority (to the extent permitted by law) as may be provided in such resolution.	
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on record reviews and interviews, the agency failed to hold meetings of the governing authority responsible for the management and operation of the agency in compliance with State Rules and Regulations. The failure to ensure that the Governing Authority meet and perform the required functions of the governing body, places all patients at risk for poor quality care. The findings is:	H1002	Attached is a copy of the approval page for the 2006 Policy and Procedure manual. The page points out the Board of Directors involvement with the Corporate Quality Assurance/Performance committee as they reviewed and accepted the manual. Also attached are copies of the sign-in sheets for the Corporate QI meetings. Included is the agenda page for one meeting which notes that the meeting was called at the request of the Governing Authority. **I. Corrective action for those patients found to be affected by the deficient practice:** No specific patients were noted in the citation as being affected by the deficiency. **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** All patients have the potential to be affected by the deficient practice. Continued on next page...	

PRINTED: 10/15/2007
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	494 8TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 1 The finding is: The agency's "Patient Bill of Rights" instructs patients of the following: "....to lodge complaints to the State of New York Department of Health at 212-613-4703....." The documented number is not the correct number to lodge a complaint with the department of health. On 6/28/07 at 2:33pm, the Regional Director was interviewed and stated that the number is incorrect.	H 222	The Board of Directors will meet biannually with a set agenda reflecting the concerns of the Corporate Quality Improvement Committee. The Corporate Quality Assurance Committee will continue to meet on a quarterly basis. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** The Board of Directors will meet biannually with a set agenda reflecting the concerns of the Corporate Quality Improvement Committee. The Board will keep a copy of the meeting agenda and a sign-in sheet to provide evidence of the meeting. The Corporate Quality Assurance Committee will continue to meet on a quarterly basis. The Committee will keep a copy of the meeting agenda and sign in sheet to provide evidence of the meeting. **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** The Vice President of Clinical Services will be responsible for setting the meeting dates and agendas for both the Board of Directors' meetings and the Corporate Quality Improvement meetings. The first of the Board of Directors meeting dates will be set after the fourth and first quarter Corporate Quality Improvement meetings and the second of the biannual meetings will occur after the second and third quarter Corporate Quality Improvement meetings. The Vice President of Clinical Services will also keep copies of the sign-in sheets and agendas for the meetings. Date of Correction: 06/25/08	
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on record reviews and interviews, the agency failed to hold meetings of the governing authority responsible for the management and operation of the agency in compliance with State Rules and Regulations. The failure to ensure that the Governing Authority meet and perform the required functions of the governing body, places all patients at risk for poor quality care. The findings is:	H1002		

PRINTED: 10/15/2007
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	494 8TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 2 There is no documented evidence of Governing Authority meetings for 2006 and 2007. The Regional Director could not provide documentation of the Governing Authority meeting minutes conducted in 2006/2007 to ensure that meetings were held. On 6/28/07 at 2:30pm, the Regional Director was interviewed and stated that the Governing Authority "does not meet unless there is an emergency".	H1002		
H1008	766.9(d) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (d) adopt and approve amendments to written policies regarding the management and operation of the home care services agency and the provision of health care services. This Rule is not met as evidenced by: Based on record review and interview, the agency did not develop policies for the Health Care Provider Network and Criminal Background Checks for employees. The Governing Authority's failure to maintain current and complete policies and procedures places the patients at risk for receiving poor quality care. The findings are: The policy and procedure manual did not contain	H1008	**H1008** A. *Note: This POC/policy was previously developed for a subsidiary of the organization and was accepted. The agency adopted a HPN policy on 10/22/07 (please see enclosure). The agency shall in-service all employees who occupy key role positions or have established HPN accounts through the organization by 03/31/08. The Executive Vice President is responsible for this corrective action plan. Employees authorized to obtain a new HPN account through the agency shall be in-serviced on the agency's HPN policy once the individual's request to obtain a HPN account is approved by the HPNC. All new HPN account users will be oriented to the agency's policy by the Branch Administrator. Continued on next page...	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585A	A. BUILDING _____ B. WING _____	06/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	494 6TH AVE NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1008	Continued From Page 3 policies and procedures for the Health Care Provider Network and Criminal Background Check. On 6/28/07 at 3:42 pm, the Regional Director was interviewed and stated that the policies will be developed.	H1008	A complete review and update of the agency's Communications Directory will be completed by 3/31/08. The agency's CIO is responsible for this corrective action. B. The Agency's Policy and Procedure Manual does have a Criminal Background Check policy (9.20 Criminal Background Checks-Fingerprinting). The policy outlines the fingerprinting and criminal background check procedures. The policy will be redistributed to all office managers by 3/31/08. The VP of Clinical Services will be responsible.	

H1002

January 11,2006

The Board of directors in conjunction with the Corporate Quality Assurance/Performance Improvement committee has reviewed the Policy and Procedure Manual and all revisions therein. For the year 2006, all policies and procedures shall be considered accepted and current unless otherwise indicated or revised.

Chief Operating Officer

Vice President of Clinical Services and Quality Management

Executive Vice President

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines
Commissioner

Wendy E. Saunders
Chief of Staff

April 18, 2008

Aaron Bethea
President
ANR Advance Home Care Services, Inc
2604 Ave U
Brooklyn, NY 11229

Re: Response to Plan of Correction
Survey Date: February 4, 2008
License: LC0424A

Dear Mr. Bethea:

Please be advised that the plan of correction relating to the recent Article 36 survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verity the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A full Survey was conducted at ANR Advance Home Care Services, Inc. on 2/4/08. Six (6) Patient Care Records were reviewed and are identified as Patients #1 - #6. Eight (8) Personnel records were reviewed and are identified as Employees #1 - #8. The agency Policy and Procedure Manual, Quality Assurance Committee Meetings and Governing Authority Meeting Minutes were reviewed.	H 000		
224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management.	H 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aaron Bethea — TITLE: President — (X6) DATE: 4/15/2008

Amended x 1

ew York State Department of Health

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From Page 1 This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to provide the patients with accurate telephone contact information to lodge a complaint with the Department of Health. Failure to provide current and accurate information places patients at risk for not being afforded their right to lodge a complaint with the Department of Health. The finding is: The agency "Patient's Rights" documents:"..... If the patient is not satisfied with the response by the agency, the patient has the right to call: State of New York Department of Health, OHSM ... (212) 613-4245..." The documented information is not the correct number to contact the Department of Health. On 2/4/08 at 2:42 pm, the Director of Operations was interviewed and did not provide an explanation.	H 224		
H 502	766.4(a) Medical orders 766.4 Medical orders. (a) The governing authority or operator shall ensure that an order from the patient's authorized practitioner is established and documented for the health care services the agency provides to those patients who: (1) are being actively treated by an authorized practitioner for a diagnosed health care problem;	H 502		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 502	Continued From Page 2 (2) have a health care need or change in physical status requiring medical intervention; or (3) are home health aide or personal care services patients of a certified home health agency. This Rule is not met as evidenced by: Based on record reviews and staff interview, the agency failed to obtain orders from an authorized practitioner for health care services. This was evident for five (5) of six (6) patient care records reviewed. (Patients # 2, 3, 4 , 5, and 6) Failure of the agency to maintain documentation of medical orders for home care services places patients at risk for not receiving services authorized by a practitioner. The findings are: 1) Patient #2 was admitted on "1/1/02" with diagnoses of Hypertension, Gastritis and Hypothyroid. The patient care record lacked documentation of medical orders for home care services by an authorized practitioner. 2) Patient #3 was admitted on "9/4/02" with diagnoses Hypertension, Arthritis and Osteoporosis. The patient care record lacked documentation of medical orders for home care services by an authorized practitioner. 3) Patient #4 was admitted on "10/3/05" with diagnoses Hypertension, Osteoporosis. The patient care record lacked documentation of	H 502		

w York State Department of Health

ATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 502	Continued From Page 3 medical orders for home care services by an authorized practitioner. 4) Patient #5 was admitted on "6/2/06" with diagnoses Parkinson's Disease and Dementia. The patient care record lacked documentation of medical orders for home care services by an authorized practitioner. 5) Patient #6 was admitted on "6/1/01" with diagnoses Hypertension, Osteoarthritis, Panic Disorder and Arthritis. The patient care record lacked documentation of medical orders for home care services by an authorized practitioner. On 2/4/08 at 11:15 am, the Director of Operations was interviewed and stated: "Usually with private patients we speak to the MD and get a verbal order for care. It is just not documented."	H 502		
H 622	766.5(c) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (c) home health aides or personal care aides are supervised, as appropriate, by a registered professional nurse or licensed practical nurse, or a therapist if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech/language pathology. This Rule is not met as evidenced by: Based on record reviews and staff interview, the	H 622	A spreadsheet was developed to assure that all home health and personal care aides who require weekly supervision prior to the return of their Criminal History Record Check, receive the mandated supervision. The Director of Nursing is responsible to communicate with the field nurses the supervision requirements of the aides, oversee the completeness of the aides' personnel record, and to change the frequency of the supervision when the Criminal History Record Check/ fingerprinting has been received.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES. INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 622	Continued From Page 4 agency failed to document supervision of Home Health Aides while awaiting the results for the Criminal History Record Check. This was evident for two (2) of eight (8) personnel records reviewed. (Employee # 1 and #2) Failure to document adequate supervision of the paraprofessional staff places all patients at risk for receiving poor quality care from potentially unqualified individuals. The findings are: 1) The personnel record for Employee #1, a Personal Care Aide, has documented date of hire as "12/19/07". The record lacks documented evidence of the required supervision while awaiting for the results of the criminal history record check. The personnel record for Employee #2, a Personal Care Aide, has documented date of hire as "3/1/07". The record lacks documented evidence of the required supervision while awaiting for the results of the criminal history record check. On 2/4/08 at 2:30pm, the Director of Operations was interviewed and stated: " I will develop a new in-home and phone supervision list."	H 622	Weekly supervision for Employee #1 and #2 has been completed, and is reflected in the nurses' supervisory notes, filed in the personnel records for Employee #1 and #2. To date, neither employee's Criminal History Record Check has been returned to ANR Advance Home Care Services, Inc., therefore, both employees are being supervised by the field nurses once a week (Employee #1 on Tuesday at 3:00 PM and Employee #2 on Thursday at 2:00 PM). The Director of Nursing conducts periodic audits to assure that all aides are supervised as mandated, that their supervision visits comply with the developed spreadsheet; the Director of Operations in collaboration with the Director of Nursing conduct periodic record audits to assure that the employees' personnel records contain the documentation necessary to support the adequacy of the supervision.	
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to	H1036		

ew York State Department of Health

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NR ADVANCE HOME CARE SERVICES. INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 5 establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Rule is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure that the Quality Improvement Committee: discusses complaints, patient care records (current and discharged); review the policy and procedure manual and have a physician present. This was evident for the agency Quality Improvement Committee meetings minutes.	H1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 6 Failure to ensure that the Quality Improvement Committee performs the required functions and contains the required members places patients at risk for poor quality services, unsafe and inadequate care. The findings are: The Quality Improvement Committee Meeting Minutes dated "1/18/07", "4/19/07", "7/30/07", "10/29/07" and "1/28/08" lacked documented evidence of discussion of all patient complaints, patient care records (current and discharged) and review of the policy and procedure manual. ." There was no documented evidence of physician attendance. On 2/4/08 at 2:40 pm, the agency Program Consultant was interviewed and stated: "The complaints are discussed. I will schedule another meeting soon to discuss these findings with everyone."	H1036		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent	H1142		

ew York State Department of Health

'ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 7 with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to develop policies and procedures for the Health Provider Network (HPN) program. Failure to develop a policy and procedure for the agency HPN account does not direct agency staff in responding to requests for information by the local health department and management in emergency situations. The finding is:	H1142		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 8 The agency policy and procedure manual lacked documentation of a policy and procedure for the agency HPN account. On 2/4/08 at 2:40 pm, the Director of Operations was interviewed and stated: "We did have them." The Director could not provide the supporting documentation.	H1142		
H1350	766.11(k) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (k) that an annual assessment of the performance and effectiveness of all personnel is conducted including at least one in-home visit to observe performance, if applicable. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure an administrative performance evaluations were completed for all personnel. This was evident in two (2) of eight (8) personnel records reviewed. (Employees #3 and #4) Failure of the agency to assess the performance and effectiveness of all employees on an annual basis places patients at risk for poor quality and unsafe care. The findings are: 1) The personnel record for Employee #3, a Personal Care Aide documents a date of hire of "6/1/01" The documented performance	H1350		

ew York State Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

\ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

X4) ID 'REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE OATE
H1350	Continued From Page 9 evaluations in the record are dated: "6/10/03" "6/5/04" and "6/9/05". There are no other documented performance evaluations in the record. 2) The personnel record for Employee #4, a Registered Nurse documents a date of hire of "10/15/01" and a date of rehire as "6/19/06". There are no documented performance evaluations in the employee file. On 2/4/08 at 2:50 pm, the agency Program Consultant was interviewed and stated: "..... it will be done."	H1350		
;354	766.11(l)(1) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (l) (1) that a program is implemented and enforced for the prevention of circumstances which could result in an employee or patient/client becoming exposed to significant risk body substances which could put them at significant risk of HIV or other blood-borne pathogen infection during the provision of services, as defined in sections 63.1 and 63.9 of this Title. Such a program shall include: (i) use of scientifically accepted protective barriers during job-related activities which involve, or may involve, exposure to significant risk body substances. Such preventive action shall be taken by the employee with each	H1354		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	Continued From Page 10 patient/client and shall constitute an essential element for the prevention of bi-directional spread of HIV or other blood-borne pathogen; (ii) use of scientifically accepted preventive practices during job-related activities which involve the use of contaminated instruments or equipment which may cause puncture injuries; (iii) training at the time of employment and yearly staff development programs on the use of protective equipment, preventive practices, and circumstances which represent a significant risk for all employees whose job-related tasks involve, or may involve, exposure to significant risk body substances; (iv) provision of personal protective equipment for employees which is appropriate to the tasks being performed; (v) a system for monitoring preventive programs to assure compliance and safety. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to ensure that all employees receive the required annual training on Universal Precaution and HIV Confidentiality. This was evident for two (2) of eight (8) personnel records reviewed. (Employee #4, and #5) Failure to ensure that employees receive the required annual in-services places patients at risk for poor quality care. The findings are: 1) The personnel record for Employee #4, a Registered Nurse, has a date of hire documented as "10/15/01" and date of re-hire	H1354	ANR Home Care Services, Inc. conducted a formal review of all employee records and has scheduled in-service training to assure that all employees and office staff were provided with training for Universal Precautions and HIV Confidentiality. Both Employee # 4 and #5 attended an in-service on April 2, 2008 and evidence of they receiving the appropriate in-service training has been filed in their employee record. Whereby an employee did not have evidence of these in-services in their employee record and was not able to attend the scheduled in-service training, the Director of Nursing provided this training by meeting these employees in the field.	

ew York State Department of Health

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	Continued From Page 11 documented as "6/19/06". The personnel file had no documented evidence of an annual in-service for Universal Precaution and HIV Confidentiality. 2) The personnel record for Employee #5, a Personal Care Aide, has a date of hire documented as "3/1/02". The documented training for Universal Precaution and HIV Confidentiality in the record is dated: "3/1/02." On 2/4/08 at 2:45pm, the Director of Operations was interviewed and confirmed that the training information is not in the file.	H1354		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments	H 000		

A full Survey was conducted at ANR Advance Home Care Services, Inc. on 2/4/08.

Six (6) Patient Care Records were reviewed and are identified as Patients #1 - #6.

Eight (8) Personnel records were reviewed and are identified as Employees #1 - #8.

The agency Policy and Procedure Manual, Quality Assurance Committee Meetings and Governing Authority Meeting Minutes were reviewed.

H 224	766.1(a)(9) Patient rights	H 224	

Section 766.1 Patient rights.

(a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to:

.....

(9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management.

ID PREFIX: H224 The Governing Authority shall establish written policies regarding patient's rights...submit complaints about care or services...the agency is also responsible for notifying the patient or his/her designee that if s/he is not satisfied patient may complain to the Department of Health's Office of Health Systems Management

PLAN OF CORRECTION: All documents representing the client's/designee's right to access the Departments of Health's Office of Health Systems Management were reviewed and where required, in the *Client's Admission Packet*, the telephone number was corrected. An in-service was presented to all senior staff on 02/25/08 concerning the client's/designee's right to be able to access this information and the agency's 'open-door' policy concerning any complaint/feedback generated by the clients and/or clients' representatives. The revised Client's Grievance Form was distributed to all active clients, providers representing ANR Advance Home Care Services and replaced the erroneous document in eh Client's Admission Packet. In addition, during two scheduled in-service training programs, the document was presented to the Home Health Aides and Personal Care Aides in attendance; the remainder of the staff is scheduled to attend an in-service on 03/25/08, at which time, it will be assure that all current staff is aware of the NYSDOH, OHSM. Attachment A represents the information provided to the clients, their designees and all persons representing the agency.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aaron Bethea — TITLE: Administrator — DATE: 4/7/08

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDE (EACH COR CROSS-REFEI	PLAN OF CORRECTION TIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

H 224 Continued From Page 1 H 224

This Rule is not met as evidenced by:
Based on record review and staff interview, the agency failed to provide the patients with accurate telephone contact information to lodge a complaint with the Department of Health.

Failure to provide current and accurate information places patients at risk for not being afforded their right to lodge a complaint with the Department of Health.

The finding is:

The agency "Patient's Rights" documents:"..... If the patient is not satisfied with the response by the agency, the patient has the right to call: State of New York Department of Health, OHSM ... (212) 613-4245..."

The documented information is not the correct number to contact the Department of Health.

On 2/4/08 at 2:42 pm, the Director of Operations was interviewed and did not provide an explanation.

H 502 766.4(a) Medical orders

766.4 Medical orders.

(a) The governing authority or operator sha ensure that an order from the patient's authorized practitioner is established and documented for the health care services the agency provides to those patients who:

(1) are being actively treated by an authoriz practitioner for a diagnosed health care prol

PLAN OF CORRECTION: To assure that all services are provided under the direction of the client's authorized practioner and that the authorized practioner is informed when there are changes in the client's medical condition, several operational changes have been made as interim procedures. A focus QPI survey was conducted on 02/07/08; the findings of this survey reflected the findings of the NYSDOH Full Survey on 02/04/08. The Director of Nursing was assigned the responsibility for ensuring that all services are authorized and this authorization is represented by a completion of one of three document, (1) the 485, (2) a M11Q or (3) Authorized Practioner's Order Form (Attachment B). A support staff person was hired, and has the responsibility of completing all biographical information on the 485/physician order form, a self-addressed stamped envelop and assure the accuracy of the provider's contact information when a client is admitted to the agency. The completed folder is forwarded to the Director of Nursing who, through her direct efforts or referral to another field supervisor, completes the 485/Authorized Practioner's Order Form, sends by facsimile when the Practioner approves this method, and sends to the Authorized Practioner the

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAC CROSS CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 502	Continued From Page 2	H 502		

(2) have a health care need or change in physical status requiring medical intervention; or

(3) are home health aide or personal care services patients of a certified home health agency.

This Rule is not met as evidenced by:

Based on record reviews and staff interview, the agency failed to obtain orders from an authorized practitioner for health care services. This was evident for five (5) of six (6) patient care records reviewed. (Patients # 2, 3, 4 , 5, and 6)

Failure of the agency to maintain documentation of medical orders for home care services places patients at risk for not receiving services authorized by a practitioner.

The findings are:

1) Patient #2 was admitted on "1/1/02" with diagnoses of Hypertension, Gastritis and Hypothyroid.

The patient care record lacked documentation of medical orders for home care services by an authorized practitioner.

2) Patient #3 was admitted on "9/4/02" with diagnoses Hypertension, Arthritis and Osteoporosis.

The patient care record lacked documentation of medical orders for home care services by an authorized practitioner.

3) Patient #4 was admitted on "10/3/05" with diagnoses Hypertension, Osteoporosis.

The patient care record lacked documentation of

written (original) document for his/her signature. The Director of Nursing assures that all orders are current and accurately reflect the condition of the client. To assure continued compliance, ANR Advance Home Care Services, Inc. has received a demonstration of an automated clinical record from August Systems (Attachment C) which will assure that an accurate 485/Practioner's order is generated. After the completion of the 485/Practioner's order, the automated document will be reviewed by The Director of Nursing and/or his/her designee and will be forwarded to the client's Authorized Practioner. Additionally, a clerical staff employee has been hired to serve as a messenger, bringing the necessary documents to the client's authorized practioner's location or procuring from the documents from the Authorized Provider. Two weeks after the procurement of orders procedures were changed, a follow-up focus review was conducted. The expected outcome at this interval was 65% compliance. ANR Advance Home Care Services, Inc. Quality and Performance Improvement Committee report revealed that the compliance threshold was 83% at that time. The agency continues to increase its compliance to this area. An additional focus survey was conducted on the day of the completion of this Plan of Correction. The compliance threshold was found to be 89%. The targeted threshold by the next Quality and Performance Improvement Committee meeting on 03/24/08 is 90%.

ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

F PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 Continued From Page 3	H 502		

medical orders for home care services by an authorized practitioner.

4) Patient #5 was admitted on "6/2/06" with diagnoses Parkinson's Disease and Dementia.

The patient care record lacked documentation of medical orders for home care services by an authorized practitioner.

5) Patient #6 was admitted on "6/1/01" with diagnoses Hypertension, Osteoarthritis, Panic Disorder and Arthritis.

The patient care record lacked documentation of medical orders for home care services by an authorized practitioner.

On 2/4/08 at 11:15 am, the Director of Operations was interviewed and stated: "Usually with private patients we speak to the MD and get a verbal order for care. It is just not documented."

766.5(c) Clinical supervision

766.5 Clinical supervision. The governing authority shall ensure for all health care service that:

.....

(c) home health aides or personal care aides are supervised, as appropriate, by a registered professional nurse or licensed practical nurse, or a therapist if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech/language pathology.

This Rule is not met as evidenced by:

Based on record reviews and staff interview, the

PLAN OF CORRECTION: The agency's policies and procedures were reviewed. The findings were that, although the appropriate level of supervision was being conducted by field nursing staff, and coordinated by The Director of Nursing/ Director of Operations, the documentation did not accurately reflect this process. To assure that those home health aides/personal care aides whose Criminal Background History has not been received by the agency are properly supervised, the Coordinator of Human Resources has created a process by which all coordinators, and The Director Of Nursing are informed when the Criminal Background History Record Check is completed, thus allowing the agency's staff to supervise the home health aide/personal care aide every two weeks or when necessitated by changes in the duties they need to conduct, and/or changes in policies, procedures and/or regulations. A focus survey was conducted on 02/21/08 to assess the degree of compliance to the change in the documentation strategies used for communicating the supervision of home health aides/personal care aides.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES. INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 622	Continued From Page 4	H 622		

agency failed to document supervision of Home Health Aides while awaiting the results for the Criminal History Record Check. This was evident for two (2) of eight (8) personnel records reviewed. (Employee # 1 and #2)

Failure to document adequate supervision of the paraprofessional staff places all patients at risk for receiving poor quality care from potentially unqualified individuals.

The findings are:

1) The personnel record for Employee #1, a Personal Care Aide, has documented date of hire as "12/19/07". The record lacks documented evidence of the required supervision while awaiting for the results of the criminal history record check.

The personnel record for Employee #2, a Personal Care Aide, has documented date of hire as "3/1/07". The record lacks documented evidence of the required supervision while awaiting for the results of the criminal history record check.

On 2/4/08 at 2:30pm, the Director of Operations was interviewed and stated: " I will develop a new in-home and phone supervision list."

H1036 766.9(l) Governing authority

Section 766.9 Governing authority.

The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall:

.....

(l) appoint a quality improvement committee to

PLAN OF CORRECTION: To assure the optimal contribution of the Quality and Performance Improvement Committee, Dr Yevgeniya Karamzena (GP) has been appointed to the QPI Committee and PAC. Dr Karamezena brings a unique set of experiences to these committees as her parents have been clients of ANR Advance Home Care Services, and she is the physician caring for several of the agency's clients. The additional members of the QPI Committee can be found on Attachment D. In order that *patient complaints* were effectively documented, and the necessary actions, contingent upon these complaints were taken, the agency's QPI policies concerning patient's complaints was reviewed by the QPI Committee. The Director of QI was identified as the senior staff who will collect the data concerning patient complaints, and interview the appropriate staff and/or provider associated to the agency, to ensure all information is reliable, that the employee about whom the complaint was made has the opportunity to provide a statement regarding his/her perceptions of the situation when it is required, and

lew York State Department of Health

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 5			

establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to:

(1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption;

(2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:

(i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and

(ii) all cases with identified patient complaints as specified in subdivision (j) of this section;

(3) prepare and submit a written summary of review findings to the governing authority for necessary action; and

(4) assist the agency in maintaining liaison with other health care providers in the community.

This Rule is not met as evidenced by:

Based on record reviews and staff interview, the agency failed to ensure that the Quality Improvement Committee: discusses complaints, patient care records (current and discharged); review the policy and procedure manual and have a physician present. This was evident for the agency Quality Improvement Committee meetings minutes.

that all complaints are effectively resolved. The mandatory survey process to analyze the nature of this information was conducted on data collected from 02/07/08 to 03/20/08. The findings of this survey were that there were few complaints by either clients (2; both of which concerned the tardiness of the home health aide/personal care aide) or their representatives (0). The coordinators who are responsible for the oversight of the work of these employees reported that tardiness was not characteristic of their conduct, but did discuss with these aides the need to be timely, and the clinical/professional importance of maintaining their schedules. To further assure that all clients have greater access to agency staff, an additional employee has been hired to augment the work of the coordinators to conduct attendance checks. In this way, the agency has been able to extend the affability with which it relates to the clients, and provides the clients an informal opportunity to discuss their experiences with agency staff. To ensure that patient care records, both current and discharged, and the review of the policy and procedure manual is a function of the QPI Committee, the function of the committee as identified in the NYSDOH regulations, and the agency's policies/procedures will be presented to the QPI Committee during its next meeting on 03/24/08. Two new procedures will be presented to the committee: (1) the procurement of authorized practioner's orders and (2) the tracking of supervision for home health or personal care aides prior to receipt of the Criminal Background History information. Additionally, a *Utilization Review* was conducted on 20 client records to pilot a new review tool and to provide focus survey data, as aforementioned. The findings of the review will be a part of the QPI Committee meeting; input from the committee will serve to direct the quality improvement initiatives necessary for greater compliance to the targeted areas. During the 2nd Quarter QPI Committee meeting, a representative sample of the number active and discharged client's records and the clinical (Disease) categories serviced by the agency will be reviewed. The findings of this Utilization Review will reported to the committee members by The Director of QI and will be a part of the agenda of the meeting for the 3rd quarter. At this time, the QPI Committee will analyze the data and the appropriate quality and performance improvement activities will be determined.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0424A	A. BUILDING _____ B. WING _____	02/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANR ADVANCE HOME CARE SERVICES, INC.	2604 AVENUE U BROOKLYN, NY 11229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	Continued From Page 11			

documented as "6/19/06".

The personnel file had no documented evidence of an annual in-service for Universal Precaution and HIV Confidentiality.

2) The personnel record for Employee #5, a Personal Care Aide, has a date of hire documented as "3/1/02".

The documented training for Universal Precaution and HIV Confidentiality in the record is dated: "3/1/02."

On 2/4/08 at 2:45pm, the Director of Operations was interviewed and confirmed that the training information is not in the file.

ID PREFIX H1354: ...the personnel file had no documented evidence of an annual in-service for Universal Precautions and HIV Confidentiality

PLAN OF CORRECTION: To assure that all employees and agency representatives are knowledgeable of the policies on Universal Precautions and HIV Confidentiality, the agency's policies and procedures were reviewed with all field nurses and nursing supervisors. The registered nurses will be responsible for providing the home health and personal care aides with these policies and the necessary tutorials to make certain that the annual presentation of this information is presented. Upon completion of each in-service, the home health and personal care aides will sign an attestation form (Attachment E) which will be a part of their permanent employee record. Additionally, during the mandatory in-services scheduled in May 2008, these policies and procedures will be reviewed.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines
Commissioner

January 9, 2008

Ms. Dawn Brill, RN
Vice President or Regional Operations-NE
Premier Home Health Care Services
360 Hamilton Ave, Suite 120
White Plains, NY 10601

Re: Response to Plan of Correction
Survey Date: November 16th 2007
License: 1086L003

Dear Ms. Brill:

Please be advised that the plan of correction relating to the attempt to perform an Article 36 survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verity the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

PREMIER
home health care services, inc.

January 3, 2008

New York State Department of Health
Metropolitan Area Regional Office
90 Church Street
New York, NY 10007
Attn: Cheryl Phoenix- Tannis, RN, MSN, CS
Program Manager- Home Health and Hospice Services

Dear Ms. Phoenix- Tannis, RN, MSN, CS

Enclosed is the Plan of Correction in response to the Statement of Deficiency, for the full survey conducted on November 16, 2007 at Premier Home Health Care Services, 1800 White Plains Road, Bronx, NY 10462.

If you have any questions, please contact me at 845-489-2395.

Sincerely,

Dawn Brill, RN
Vice President of Regional Operations- North East

cc: File

Enclosure

RECEIVED
JAN 0 4 2008

360 Hamilton Avenue, Suite 120, White Plains, New York 10601 Phone 914-428-7722 Fax 914-428-2404

w York State Department of Health

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

... OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

4) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full Survey was conducted at Premier Home Health Care Services, Inc. on November 16, 2007. Five (5) Patient Records were reviewed and are identified as Patients #1 to #5. Seven (7) Personnel Records were reviewed and are identified as Employees #1 to #7. The agency Policy and Procedure Manual, Federal Tax ID, Quality Improvement/Quality Assurance Committee Meeting Minutes, and Admission Packet were reviewed.	H 000		
204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges; (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient.	H 204	H204 As part of the admission process, it is the Policy of Premier Home Health Care Service (#15.3) for the Field Nurse Supervisor to review the Patient Bill Of Rights Document , and obtain the patient's or patient's representative's signature. A copy of the signed Patient Bill Of Rights is filed in the patient's clinical file and a copy is provided to the patient. **I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** • The Field Nurse Supervisor will perform a home visit to patients #1, #2, #3, #4, #5 who were noted to have the deficiency upon DOH survey. The Field Nurse Supervisor will review the Patient Bill Of Rights, and obtain the	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Vice President of Regional Operations - North East — 1-3-08

T. FORM 021199 — If continuation sheets, 1 of 20

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 1 (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to provide the patients (at the initiation of care) with written information regarding the specific services to be provided and the financial liability. This was evident for five (5) out of five (5) records reviewed. (Patient records # 1,2,3,4 and 5) Failure to inform the patient of the services to be provided and the financial liability places the patients at risk for not being fully informed of all their rights. The findings are: 1)Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The patient care record lacked documented evidence that the patient was informed of the services to be provided.	H 204	patient's or patient's representative's signature. A copy of the signed Patient Bill Of Rights will be filed in the patient's clinical file and a copy will be provided to the patient. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Director of Patient Services, and Field Nurse Supervisor Date of Completion: 4/4/08 **II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** • All active private pay files will be audited to assess if the Patient Bill Of Rights is present and signed in the patient's clinical file. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Director of Patient Services, and Field Nurse Supervisor Date of Completion: 4/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** • All Field Nurse Supervisors and the Administrator will be re in-serviced on Policy (#15.3) Patient Bill Of Rights, as well as the Patient Bill Of Rights Document that requires a patient or patient's representative's signature, and filing in patient's clinical file.	

ew York State Department of Health

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 2 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The patient care record lacked documented evidence that the patient was informed of the services to be provided and financial liability. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record lacked documented evidence that the patient was informed of the services to be provided and financial liability. 4) Patient #4 was admitted on 3/1/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia. The patient care record documents that the patient was informed of their rights, the services to be provided and financial liability on 4/17/07. 5) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The patient care record lacked documented evidence that the patient was informed of the services to be provided and financial liability. On November 16, 2007 at 3:40pm, the Operations Manager was interviewed and stated: "the corporate office is interviewing a nurse today for the field nurse position. Because of the lack of field nurses we have had to do the best we can."	H 204	Parties responsible for the correction and ensuring continued compliance: Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **IV. How the corrective action will be monitored to ensure the deficient practice will not recur** • 25% of the active private pay client's files will be audited each month to assess if the Patient Bill Of Rights is present and signed in the patient's clinical file. Parties responsible for the correction and ensuring continued compliance: Heather Simon - Office Administrator, Field Nurse Supervisor, and Director of Patient Services, and Celestina Cruz, RN Vice President of Clinical Service. Date of Completion: 4/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From Page 3	H 224		
H 224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined that the agency failed to provide accurate telephone contact information to lodge a complaint with the Department of Health . This was evident for 4 of 4 patients reviewed. (Patients # 1,2,3 and 4) Failure to provide current and accurate information places patients at risk for not being afforded their right to lodge a complaint with the Department of Health. The findings are:	H 224	H224 As part of the admission process, it is the Policy of Premier Home Health Care Service (#7.4) for the Field Nurse Supervisor to inform the patient in writing of their right to voice concerns or complaints about the care or services provided by Premier, and the procedures for filing such concerns or complaints. The Field Nurse Supervisor provides the patient or patient's representative with a Patients Bill Of Rights as well as Premier's Complaint/Occurrence Involving Patient Services Form; they provide the process for filing a complaint, and the numbers to the patient's Premier Branch, the Department of Health, and the Joint Commission Hotline. **I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** • The Field Nurse Supervisor will perform a home visit to patients #1, #2, #3, #5, who were noted to have the deficiency upon DOH survey. The Field Nurse Supervisor will review the Patient Bill Of Rights with the correct Department of Health's phone number, and obtain the patient's or patient's representative's signature. A copy of the signed Patient Bill Of Rights will be filed in the patient's clinical file and a copy will be provided to the patient.	

ew York State Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From Page 4 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The patient care record included documented evidence of the patient's receipt of the agency Patient Bill of Rights on 5/2/03 with the phone number for the Department documented "212-788-9648" and on 5/21/07 with the phone number for the Department documented as "212-588-4771" . The documented number is not the correct information to contact the New York State Department of Health. 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension The patient care record has documented evidence of the patient's receipt of the agency "Patient Bill of Rights" on 11/13/04. In the the documents, the space to write the phone number of the Department of Health is blank. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record has documented evidence of the patient's receipt of the Patient Bill of Rights on 4/3/06 with the phone number for the Department of Health documented as "212-268-6689." 4) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The patient care record has documented evidence of the patient's receipt of the Patient Bill of Rights on 10/7/05 with the phone number for	H 224	The Field Nurse Supervisor will review Premier's Complaint/Occurrence Involving Patient Services Form that provides Premier's branch phone number and the phone number to the Joint Commission Hotline. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Director of Patient Services, and Field Nurse Supervisor Date of Completion: 4/4/08 **II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** • All active private pay files will be audited to assess if the Patient Bill Of Rights is present, signed, and has the correct phone number to the Department of Health, and that the patient received Premier's Complaint/Occurrence Involving Patient Services Form. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Director of Patient Services, and Field Nurse Supervisor Date of Completion: 4/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** • All Field Nurse Supervisors and the Administrator will be re in-serviced on	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From Page 4 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The patient care record included documented evidence of the patient's receipt of the agency Patient Bill of Rights on 5/2/03 with the phone number for the Department documented "212-788-9648" and on 5/21/07 with the phone number for the Department documented as "212-588-4771" . The documented number is not the correct information to contact the New York State Department of Health. 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension The patient care record has documented evidence of the patient's receipt of the agency "Patient Bill of Rights" on 11/13/04. In the the documents, the space to write the phone number of the Department of Health is blank. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record has documented evidence of the patient's receipt of the Patient Bill of Rights on 4/3/06 with the phone number for the Department of Health documented as "212-268-6689." 4) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The patient care record has documented evidence of the patient's receipt of the Patient Bill of Rights on 10/7/05 with the phone number for	H 224	Policy (# 7.4). The in-service will include the Patient Bill Of Rights and ensure that the correct Department of Health's phone number is provided, as well as Premier's Complaint/Occurrence Involving Patient Services Form with Premier's branch telephone number, and the Joint Commissions Hotline number. Parties responsible for the correction and ensuring continued compliance: Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **IV. How the corrective action will be monitored to ensure the deficient practice will not recur** • 25% of the active private pay client's files will be audited each month to assess if the Patient Bill Of Rights is present, has the correct phone number to the department of health, and is signed in the patient's clinical file. The Field Nurse Supervisor must also note that she has presented Premier's Complaint/Occurrence Involving Patient Services Form with Premier's branch telephone number, and the Joint Commissions Hotline number. Parties responsible for the correction and ensuring continued compliance: Heather Simon - Office Administrator, Field Nurse Supervisor, and Director of Patient Services, and Celestina Cruz, RN Vice President of Clinical Service. Date of Completion: 4/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	

w York State Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES. INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From Page 5 the Department of Health documented as "212-268-6689." The documented numbers is not the correct information to contact the New York State Department of Health. On November 16, 2007 at 3:45pm, the Operations Director was interviewed and stated: "..... I did not know."	H 224		
H 408	766.3(d) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months; (1) each review shall be documented in the clinical record; and (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to review the plan of care for patients. This was noted for five (5) of five (5) records reviewed. (Patients # 1, #2, #3, #4, and #5) Failure of the agency to ensure that patient care	H 408	H 408 It is the Policy of Premier Home Health Care Service (#14.3) that the Field Nurse Supervisor develops a Plan of Care for each patient upon admission. The Field Nurse Supervisor must also review/revise the Plan of Care as necessary and at least every six months. **I. Corrective action will be accomplished for those patients found to have been affected by the deficient practice.** The Field Nurse Supervisor is to: • Arrange and perform a home visit to patients #1, #2, #3, #4, #5 that were found to be deficient upon the DOH survey. • Review and revise the care plan to meet the client's present needs. • Complete the physician telephone orders and obtain a physician signature. • Document visit and findings in client's file. Parties responsible for the correction and ensuring continued compliance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From Page 6 plans are updated to reflect the changing needs of the patient, places all patients at risk of unsafe, poor quality care. The findings are: 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The "Home Health Certification and Plan of Treatment" dated for the certification period of 5/4/03 to 11/4/03 and certification period dated 11/4/03 to 4/4/04, which was signed by the MD on 1/26/04 have no documented evidence of review since 2004. 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The "Home Health Certification and Plan of Treatment" for the certification period dated 6/21/07 to 12/22/07 has no documented evidence of review prior to this certification period in the patient's care record. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record has no documented evidence of Home Health Certifications and Plan of Treatments. 4) Patient #4 was admitted on 3/1/07 with a diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia. The "Home Health Certification and Plan of Treatment" for the certification period dated	H 408	Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services Date of Completion: 4/4/08 **II. How to identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken** • Care plans on all active private pay charts will be reviewed for content, need for revision, and documentation. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** Per Policy 14.3 Plan of Care – When the patient's condition changes, the RN modifies the care plan and notifies the physician of any needed new or revised orders.	

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

D IX ;	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
408	Continued From Page 6 plans are updated to reflect the changing needs of the patient, places all patients at risk of unsafe, poor quality care. The findings are: 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The "Home Health Certification and Plan of Treatment" dated for the certification period of 5/4/03 to 11/4/03 and certification period dated 11/4/03 to 4/4/04, which was signed by the MD on 1/26/04 have no documented evidence of review since 2004. 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The "Home Health Certification and Plan of Treatment" for the certification period dated 6/21/07 to 12/22/07 has no documented evidence of review prior to this certification period in the patient's care record. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record has no documented evidence of Home Health Certifications and Plan of Treatments. 4) Patient #4 was admitted on 3/1/07 with a diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia. The "Home Health Certification and Plan of Treatment" for the certification period dated	H 408	Procedure: - The Staffing Coordinator will inform the Field Nurse Supervisor of schedule changes due to: - Change in client status. • Client/Family requesting change in hours. The Field Nurse Supervisor is to adhere to the following when there is a change in client status: • Document in the nursing narrative that she has received a notice of change in client status. • Arrange and perform a home visit. • Reviews and revises care plan to meet the client's present needs. Instruct aide on revised plan of care. • Complete the physician telephone orders and obtain physician signature. • Document visit and findings in client's file. The RN is to adhere to the following when the client/family requests a change in hours: • Document in the nursing narrative that she has received a notice of change in hours. • Contact the client/family to assess reason for change in hours. Arranges and performs home visit if required. • Reviews and revises care plan to meet client's present needs. Instruct aide on revised plan of care. • Completes physician telephone orders and obtains physician signature. • Document visit and findings in client's file.	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From Page 6	H 408		

plans are updated to reflect the changing needs of the patient, places all patients at risk of unsafe, poor quality care.

The findings are:

1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia.

The "Home Health Certification and Plan of Treatment" dated for the certification period of 5/4/03 to 11/4/03 and certification period dated 11/4/03 to 4/4/04, which was signed by the MD on 1/26/04 have no documented evidence of review since 2004.

2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension.

The "Home Health Certification and Plan of Treatment" for the certification period dated 6/21/07 to 12/22/07 has no documented evidence of review prior to this certification period in the patient's care record.

3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures.

The patient care record has no documented evidence of Home Health Certifications and Plan of Treatments.

4) Patient #4 was admitted on 3/1/07 with a diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia.

The "Home Health Certification and Plan of Treatment" for the certification period dated

•Staffing Coordinators, Office Administrator, and Field Nurse Supervisors will be in-serviced on the above.
Parties responsible for the correction and ensuring continued compliance Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services
Date of Completion: 4/4/08

IV. How the corrective action will be monitored to ensure the deficient practice will not recur
• 25% of the active private pay client's will be audited each month for plan of care content, revision, and documentation.
Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services
Date of Completion: 4/4/08

Dawn Brill, RN
Vice President of Regional Operations- North East

ew York State Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From Page 7 6/13/07 to 12/13/07 has no documented evidence of review prior to this certification period. 5) Patient #5 was admitted on 9/27/05 with a diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The "Home Health Certification and Plan of Treatment" for the certification period dated 1/31/07 to 7/31/07 was not signed or dated by the physician. There were no documented evidence of review prior or after this certification period. On November 16, 2007 at 3:25pm, the Operations Manager was interviewed and stated: "The DPS recently resigned and two other field nurses were terminated we have had to start new books for the patients because we could not find previous paperwork."	H 408		
H 622	766.5(c) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (c) home health aides or personal care aides are supervised, as appropriate, by a registered professional nurse or licensed practical nurse, or a therapist if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech/language pathology. This Rule is not met as evidenced by: Based on record reviews and staff interview, the agency failed to document complete supervision of the paraprofessional staff while awaiting the	H 622	H622 It is the Policy of Premier Home Health Care Service (#9.20) that all paraprofessional staff receives supervision while awaiting the results of their Criminal History Record Check, per the Department of Health Regulations. Employees will be telephone supervised and field supervised on alternate weeks, until the employees criminal background check results are obtained by Premier.	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 622	Continued From Page 8 results for the Criminal History Record Check. This was evident for one (1) out of four (4) records reviewed. (Employee # 4) Failure to document adequate supervision of the paraprofessional staff places all patients at risk for receiving poor quality care from potentially unqualified individuals. The Findings are: The personnel record for Employee record #4.(Home Health Aide) documents a hire date of "2/9/07". The record lacks documented evidence of supervision while awaiting for the results of the criminal history record check. Documentation of supervision for the weeks of 2/19/07 and 3/26/07; the whole month of April; the weeks of 5/5/07-5/16/07, the last two weeks of July,2007; the month of August,2007 and the week of 10/15/07 were missing from the record. On November 16, 2007 at 3:33pm, the Operations Manager was interviewed and stated: "the nurses were supposed to be doing this and when they left we found a lot of paperwork missing."	H 622	**I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** • The personnel file of employee #4 will be reviewed to ensure that the Criminal Background Check has returned. If the Criminal Background Check has not returned, Premier's Policy #9.20 should be adhered to. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Field Nurse Supervisor, and Director of Patient Services. Date of Completion: 4/4/08 **II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** • The personnel files of all provisional employees will be audited to ensure that they are being supervised in accordance with the Department of Health Regulations.	
H 708	766.6(a)(3) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (3) nursing assessments conducted to provide services.	H 708		

N York State Department of Health

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

AE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 622	Continued From Page 8 results for the Criminal History Record Check. This was evident for one (1) out of four (4) records reviewed. (Employee # 4) Failure to document adequate supervision of the paraprofessional staff places all patients at risk for receiving poor quality care from potentially unqualified individuals. The Findings are: The personnel record for Employee record #4,(Home Health Aide) documents a hire date of "2/9/07". The record lacks documented evidence of supervision while awaiting for the results of the criminal history record check. Documentation of supervision for the weeks of 2/19/07 and 3/26/07; the whole month of April; the weeks of 5/5/07-5/16/07, the last two weeks of July,2007; the month of August,2007 and the week of 10/15/07 were missing from the record. On November 16, 2007 at 3:33pm, the Operations Manager was interviewed and stated: "the nurses were supposed to be doing this and when they left we found a lot of paperwork missing."	H 622	Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, HR Coordinators, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** • All Field Nurse Supervisors, Office Administrator, HR Coordinators will be re in-serviced on Policy (# 9.20). Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, HR Coordinators, Field Nurse Supervisor, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08	
H 708	766.6(a)(3) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (3) nursing assessments conducted to provide services.	H 708		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 622	Continued From Page 8 results for the Criminal History Record Check. This was evident for one (1) out of four (4) records reviewed. (Employee # 4) Failure to document adequate supervision of the paraprofessional staff places all patients at risk for receiving poor quality care from potentially unqualified individuals. The Findings are: The personnel record for Employee record #4,(Home Health Aide) documents a hire date of "2/9/07". The record lacks documented evidence of supervision while awaiting for the results of the criminal history record check. Documentation of supervision for the weeks of 2/19/07 and 3/26/07; the whole month of April; the weeks of 5/5/07-5/16/07, the last two weeks of July,2007; the month of August,2007 and the week of 10/15/07 were missing from the record. On November 16, 2007 at 3:33pm, the Operations Manager was interviewed and stated: "the nurses were supposed to be doing this and when they left we found a lot of paperwork missing."	H 622	**IV. How the corrective action will be monitored to ensure the deficient practice will not recur** • 25% of the personnel files of all provisional employees will be audited monthly to ensure that they are being supervised in accordance with the Department of Health Regulations. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, HR Coordinators Field Nurse Supervisor, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	
H 708	766.6(a)(3) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (3) nursing assessments conducted to provide services.	H 708	H708 It is the Policy of Premier Home Health Care Services (# 11.6) that the Field Nurse Supervisor completes an Initial Nursing Assessment at the time of admission.	

ew York State Department of Health

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 708	Continued From Page 9 This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that a nursing assessment is conducted on all patients. This was evident for three (3) of five (5) records reviewed. (Patient Care Records 1,2 and 5) Failure of the agency to ensure complete documentation of nursing assessments places all patients at risk for poor quality care. The findings are: 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The patient care record does not contain documented evidence of a complete initial nursing assessment. 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The patient care record does not contain documented evidence of a complete initial nursing assessment. 3) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The care record does not contain documented evidence of a nursing assessment for 2007. On November 16, 2007 at 3:55pm, the Operations Manager was interviewed and stated: "..... we have not had a field nurse in a while and the ones we had were terminated."	H 708	**I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** • The Field Nurse Supervisor will perform a home visit and complete an Initial Nursing Assessment on patients #1, #2, #5 that were found deficient during the DOH survey. The Initial Nursing Assessment will be placed in the patient's clinical file. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** • The clinical files of all active clients will be audited for the presence and completion of the Initial Nursing Assessment. Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08	

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 708	Continued From Page 9	H 708		

This Rule is not met as evidenced by:
Based on record review and staff interview, the agency failed to ensure that a nursing assessment is conducted on all patients. This was evident for three (3) of five (5) records reviewed. (Patient Care Records 1,2 and 5)

Failure of the agency to ensure complete documentation of nursing assessments places all patients at risk for poor quality care.

The findings are:

1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia.

The patient care record does not contain documented evidence of a complete initial nursing assessment.

2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension.

The patient care record does not contain documented evidence of a complete initial nursing assessment.

3) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness.

The care record does not contain documented evidence of a nursing assessment for 2007.

On November 16, 2007 at 3:55pm, the Operations Manager was interviewed and stated: "..... we have not had a field nurse in a while and the ones we had were terminated."

III. Measures that will be put in place to ensure that the deficient practice will not recur

- The Field Nurse Supervisors and Office Administrator will be re in-services on Policy #11.6.

Parties responsible for the correction and ensuring continued compliance: Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services.
Date of Completion: 4/4/08

IV. How the corrective action will be monitored to ensure the deficient practice will not recur

- 25% of the clinical files of all active private pay clients will be audited monthly for the presence and completion of the Initial Nursing Assessment

Parties responsible for the correction and ensuring continued compliance: Heather Simon- Office Administrator, Field Nurse Supervisor, Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services.
Date of Completion: 4/4/08

Dawn Brill, RN
Vice President of Regional Operations- North East

w York State Department of Health

TEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES. INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462.

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 708	Continued From Page 10	H 708		
H 712	766.6(a)(5) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (5) signed and dated progress notes following each patient visit or phone contact by all professional personnel providing care which include a summary of patient status and response to the plan of care and any contacts with family, informal supports and other community resources that are relevant to the patient's condition and treatment. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to maintain documentation of patient progress in the patient care records. This was evident for five (5) of five (5) records reviewed. (Patient Care Records #1, # 2, #3, #4,and #5) Failure of the agency to document patient care places all patients at risk of unsafe, poor quality care. The findings are: 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The patient care record does not include progress notes to document patient contact and progress.	H 712	H712 It is the Policy of Premier Home Health Care Services (# 11.6) that the Field Nurse Supervisor performs home visits after the initial nursing assessment to the patient as ordered by the physician, for patient reassessment, patient teaching, and aide supervision. The Field Nurse Supervisor is to document all home visits and telephone calls in the patient's clinical file. **I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** • The Field Nurse Supervisor will perform a home visit and complete documentation on patients #1, #2, #3, #4, #5 that were found deficient during the DOH survey. The home visit documentation will be placed in the patient's clinical file. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 712	Continued From Page 11 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The patient care record does not include progress notes to document patient contact and progress. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record does not include progress notes to document patient contact and progress. 4) Patient #4 was admitted on 3/1/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia. The patient care record does not include progress notes to document patient contact and progress. 5) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The patient care record does not include progress notes to document patient contact and progress. On November 16, 2007 at 3:28pm, the Operations Manager was interviewed and stated: "..... The nurses were to be documenting all contact and they were terminated mainly because of this."	H 712	**II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** • The clinical files of all active private pay clients will be audited for the presence and completion of patient home visits, telephone calls, and all associated progress notes.. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** • The Field Nurse Supervisors and Office Administrator will be re in-serviced on Policy #11.6. Parties responsible for the correction and ensuring continued compliance: Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **IV. How the corrective action will be monitored to ensure the deficient practice will not recur** • 25% of the clinical files of all active private pay clients will be audited monthly for the presence and completion of home visits, telephone communication, and all associated progress notes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 712	Continued From Page 11 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The patient care record does not include progress notes to document patient contact and progress. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record does not include progress notes to document patient contact and progress. 4) Patient #4 was admitted on 3/1/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia. The patient care record does not include progress notes to document patient contact and progress. 5) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The patient care record does not include progress notes to document patient contact and progress. On November 16, 2007 at 3:28pm, the Operations Manager was interviewed and stated: "....The nurses were to be documenting all contact and they were terminated mainly because of this."	H 712	Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From Page 12	H 714	H714 It is the Policy of Premier Home Health Care Services (# 12.2) that the Field Nurse Supervisor is responsible for the supervision of services and care provided by the home health aide. Upon each home visit to the patient, the Field Nurse Supervisor completes a Paraprofessional Supervisory Evaluation Form that documents her findings and supervision of the home health aide during that visit. **I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** • The Field Nurse Supervisor will perform a supervisory home visit and complete the Paraprofessional Supervisory Evaluation Form for home health aides that are assigned to patients #1, #2, #3, #4, #5 that were found deficient during the DOH survey. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** • The clinical files of all active private pay clients will be audited for the presence and completion of home	
H 714	766.6(a)(6) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (6) supervisory reports of the registered professional nurse, licensed practical nurse or the therapist, if applicable, of the home health aide or personal care aide. This Rule is not met as evidenced by: Based on record reviews and staff interview, the agency failed to document supervisory reports in five (5) out of five (5)patient care records reviewed. Failure to document adequate supervision of the services and care provided by their staff places all patients at risk for receiving poor patient care. The findings are: 1) Patient #1 was admitted on 5/4/03 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Retinopathy and Pneumonia. The order document that the patient is to receive "3 days 4 hours a day of Home Health Aide services." There is no documented evidence of supervision for the Home Health Aide after 12/25/06. 2) Patient #2 was admitted on 4/22/04 with diagnoses of Cerebrovascular Accident with left Hemiparesis and Hypertension. The orders	H 714		

ew York State Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From Page 13 document that the patient is to receive "6 days 6 hours a day of Home Health Aide services." There is no documented evidence of supervision of Home Health Aide supervision for 2006 or 2007. 3) Patient #3 was admitted on 4/1/06 with diagnoses of Muscular Dystrophy and Seizures. The patient care record has an authorization form which documents for the patient to receive: "6 hours 7 days of Personal Care Aide services." The patient record did not contain documented evidence Personal Car Aide supervision. 4) Patient #4 was admitted on 3/1/07 with diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer, Hypertension and Hyperlipidemia. The orders documents that the patient is to receive: "5 days 4 hours of Personal Care Aide services." The patient care record does not contain documented evidence of Personal Care Aide supervision. 5) Patient #5 was admitted on 9/27/05 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension and Blindness. The orders document for the patient to receive: "5 days 6 hours of Home Health Aide services". The patient care record does not contain documented evidence of Home Health Aide supervision for 2007.	H 714	health aide supervisory visits, and the completion of the Paraprofessional Supervisory Evaluation Form. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** • The Field Nurse Supervisors and Office Administrator will be re in-serviced on Policy #11.6. Parties responsible for the correction and ensuring continued compliance: Director of Patient Services, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **IV. How the corrective action will be monitored to ensure the deficient practice will not recur** • 25% of the clinical files of all active private pay clients will be audited monthly for the presence and completion of supervisory home visits of the home health aides, and completion of the Paraprofessional Supervisory Evaluation Form. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Office Administrator,	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From Page 14 On November 16, 2007 at 3:50pm the Operations Manager was interviewed and stated: "the two nurses that were terminated were supposed to provide the supervision."	H 714	and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **Dawn Brill, RN** **VP of Regional Operations- North East**	
H1020	766.9(j) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (j) ensure the development and implementation of a patient complaint procedure to include: (1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received by the agency; (2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint: (i) explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and (ii) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed; (3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal; and	H1020	H1020 As part of the admission process, it is the Policy of Premier Home Health Care Service (#7.4) for the Field Nurse Supervisor to inform the patient in writing of their right to voice concerns or complaints about the care or services provided by Premier, and the procedures for filing such concerns or complaints. Policy (#7.4) also outlines the procedure for processing all reported complaints including: Staff completion of the Complaint/Occurrence Report (Form-C110) which includes all relevant information, the investigation, outcome, resolution, and follow-up actions. The Office Administrator is responsible for ensuring that this form is completed and forward to the Vice President of Clinical Services. The Vice President prepares a written response to all written and oral complaints if requested, and the decision of the agency within 15 days of receiving the complaint. The person making the complaint has the right to appeal the Agency's decision by having the Agency's Chief Operating Officer review the appeal. If the patient is not satisfied with the Agency's response that patient may forward their complaint to the Department of Health. All Complaints are to be tracked on the Complaint Log (Form- C103) and filed in the Complaint Log Binder.	

w York State Department of Health

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 15 (4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management. This Rule is not met as evidenced by:. Based on record review and staff interview, the agency failed to maintain a complaint log to document the receipt and resolution of complaints received by the agency. Failure to ensure that an accurate and complete complaint log is maintained places all patients at risk for poor quality patient care. The finding is: The agency presented an "Occurrence Log" book when the complaint log was requested. There was no documented evidence of an agency complaint log to document complaint investigations and resolutions. On November 16, 2007 at 3:10pm, the Operations Manager was interviewed and was unable to provide an explanation.	H1020	**I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** **II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** **III. Measures that will be put in place to ensure that the deficient practice will not recur** • Re In-Service all Office Staff on Policy # 7.4: This will include the completion of the Complaint/Occurrence Report (Form C110), verbally notifying and faxing the Vice President of Clinical Services per the Complaint Level, placing all complaints on the Complaint Log (Form-C103) and filing in the complaint binder by quarter, and reporting complaints at each quarterly QI Meeting. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Heather Simon- Office Administrator, Director of Patient Services, and Celestina Cruz, RN – Vice President of Clinical Services. Date of Completion: 4/4/08	
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional	H1036		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 15 (4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to maintain a complaint log to document the receipt and resolution of complaints received by the agency. Failure to ensure that an accurate and complete complaint log is maintained places all patients at risk for poor quality patient care. The finding is: The agency presented an "Occurrence Log" book when the complaint log was requested. There was no documented evidence of an agency complaint log to document complaint investigations and resolutions. On November 16, 2007 at 3:10pm, the Operations Manager was interviewed and was unable to provide an explanation.	H1020	**IV. How the corrective action will be monitored to ensure the deficient practice will not recur** It is the responsibility of the Office Administrator to ensure that the complaint received has been documented, communicated to the VP of Clinical Services, filed accordingly, and presented and the Quarterly QI Meetings per Policy # 7.4. Celestina Cruz, RN, Vice President of Clinical Services will review the complaint Policy with the Office Administrator and monitor the complaints monthly and quarterly. Parties responsible for the correction and ensuring continued compliance: Field Nurse Supervisor, Director of Patient Services, Heather Simon- Office Administrator, Director of Patient Services, and Celestina Cruz, RN – Vice President of Clinical Services. Date of Completion: 4/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional	H1036	H1036 766.9 It is Premier's Policy (#7.1) to provide a Quality Improvement Program and Committee that establishes and oversees the standards of care. The Corporate Quality Improvement Committee consists of a Consumer, Physician, Regional Vice Presidents, and Regional Directors of Patient Services.	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES. INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 16 persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Rule is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the QA/QI Committee met four times a year; the meetings include a physician and a consumer and the committee performs the random record review of patients that are currently receiving services and patients discharged from the agency within the past three (3) months as well as all cases with identified patient complaints. Failure to ensure that the Quality Improvement Committee performs the required functions	H1036	The Committee meets quarterly to review: policies, initiatives, clinical record audits, complaints, and submits a written summary of review findings to the governing authority. The Regional Quality Improvement Committee consists of the Regional Director of Patient Services, Regional Vice President, Field Nurse Supervisors, and Coordinators. The Committee meets quarterly to review: policies, initiatives, clinical record audits, complaints, and submits a written summary to the Corporate Committee. Attached are the Corporate QI Minutes for 2007. Dr. Banc served as both the Physician and the Consumer. **I. Measures that will be put in place to ensure that the deficient practice will not recur** The Staff will be re in-serviced on Policy #7.1 Parties responsible for the correction and ensuring continued compliance: Office Administrator, Director of Patient Services, and Celestina Cruz, RN – Vice President of Clinical Services. Date of Completion: 2/4/08 **II. How the corrective action will be monitored to ensure the deficient practice will not recur** The Vice President of Clinical Services will attend the First Quarter QI Meeting for the Bronx Office, and will monitor all QI Meeting documentation for 2008. Parties responsible for the correction and ensuring continued compliance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 17 places patients at risk for poor quality services, unsafe and inadequate care. The findings are: The Quality Improvement (QI) meeting minutes for First Quarter 2007, dated May 17, 2007 and Quality Improvement meeting minutes for Second Quarter 2007. dated September 27, 2007 lacked documented evidence of the attendance of a physician and a consumer. The (QI) meeting minutes lacked documentation of the random review of patient records currently receiving services, patients that were discharged within the past three months and cases with identified patient complaints. As per the agency staff, the Quality Improvement Committee Meeting Minutes for the Year 2006 were "not available" for review as it was "in the Corporate office" and "unable to be faxed". On November 16, 2007 at 3:06pm, the Operations Manager was interviewed and stated: "..... the corporate office has the QI meeting minutes....."	H1036	Office Administrator, Director of Patient Services, and Celestina Cruz, RN – Vice President of Clinical Services. Date of Completion: 2/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	
H1306	766.11(c) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (c) that the health status of all new personnel is assessed and documented prior to assuming patient care duties. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health	H1306	H1306 766.11 It is the Policy of Premier Home Health Care Services (# 9.7 Drug Free Work Place, #9.8 Field Caregiver Physical) that the potential employee undergo a Pre-employment Physical (E111) that includes a forensic drug screen. The forensic drug screen is also completed yearly thereafter at the time of the required Annual Health Assessment (E125). This practice has been in effect	

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1306	Continued From Page 18 impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Rule is not met as evidenced by: Based on record reviews and interviews, the agency failed to obtain " Freedom of Habituation to Drugs and Alcohol " statements and annual health assessment from employees. This was evident for 3 of 4 personnel files reviewed. (Employees # 1, 2 and 3) Failure of the agency to ensure that all employees are free from the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior places all patients at risk for unsafe care. The findings are: The Personnel files for Employees #1 ,2 and #3 did not include documentation of statements that the employees are "free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individuals's behavior." The personnel files for Employee # 1(Home Health Aide) and Employee # 3 (Registered Nurse) do not include health assessments health status assessment on file for Employee # 1 is dated "5/31/06". On 11/16/07 at 3:00pm, the Operations Manager was interviewed and was unable to provide an explanation.	H1306	since 1996 and lab results pertaining to the forensic drug screen can be found in the medical records section of the employee's personnel file. The agency's Health Assessment Form (E125) and Pre-Employment Physical (E111) were modified on 4/5/07, to include that the potential employee and existing employee are free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior. **I. Corrective actions that will be accomplished for those patients found to have been affected by the deficient practice.** Personnel #1, #2, #3 will complete the updated Annual Health Assessment Form (E125), that includes the statement free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior. All remaining employees will complete the updated Annual Health Assessment Form (E125) during the 2008 calendar year at their scheduled yearly due date. Parties responsible for the correction and ensuring continued compliance: Employment Coordinators, Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 2/4/08	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1306	Continued From Page 18 impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Rule is not met as evidenced by: Based on record reviews and interviews, the agency failed to obtain " Freedom of Habituation to Drugs and Alcohol " statements and annual health assessment from employees. This was evident for 3 of 4 personnel files reviewed. (Employees # 1, 2 and 3) Failure of the agency to ensure that all employees are free from the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior places all patients at risk for unsafe care. The findings are: The Personnel files for Employees #1 ,2 and #3 did not include documentation of statements that the employees are "free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individuals's behavior." The personnel files for Employee # 1(Home Health Aide) and Employee # 3 (Registered Nurse) do not include health assessments health status assessment on file for Employee # 1 is dated "5/31/06". On 11/16/07 at 3:00pm, the Operations Manager was interviewed and was unable to provide an explanation.	H1306	**II. How to identify other client's having the potential to be affected by the same deficient practice and what corrective action will be taken.** All remaining employees will complete the updated Annual Health Assessment Form (E125) during the 2008 calendar year at their scheduled yearly due date. All potential employees will complete an updated Pre-employment Physical (E111) Parties responsible for the correction and ensuring continued compliance: Employment Coordinators, Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 2/4/08 **III. Measures that will be put in place to ensure that the deficient practice will not recur** All Office staff will be re in-serviced on Policy #9.7, #9.8, and the updated Pre-Employment Physical (E111) and the updated Annual Health Assessment (E125), that are located in the forms directory. Parties responsible for the correction and ensuring continued compliance: Employment Coordinators Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 2/4/08	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

= OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1306	Continued From Page 18 impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This Rule is not met as evidenced by: Based on record reviews and interviews, the agency failed to obtain " Freedom of Habituation to Drugs and Alcohol " statements and annual health assessment from employees. This was evident for 3 of 4 personnel files reviewed. (Employees # 1, 2 and 3) Failure of the agency to ensure that all employees are free from the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior places all patients at risk for unsafe care. The findings are: The Personnel files for Employees #1 ,2 and #3 did not include documentation of statements that the employees are "free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individuals's behavior." The personnel files for Employee # 1(Home Health Aide) and Employee # 3 (Registered Nurse) do not include health assessments health status assessment on file for Employee # 1 is dated "5/31/06". On 11/16/07 at 3:00pm, the Operations Manager was interviewed and was unable to provide an explanation.	H1306	**IV. How the corrective action will be monitored to ensure the deficient practice will not recur** • 25% of the employee personnel files will be audited monthly for the presence and completion of the updated Pre-Employment Physical (E111) and the updated Annual Health Assessment (E125) that refer to the statement free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior. Parties responsible for the correction and ensuring continued compliance: Employment Coordinators, Field Nurse Supervisor, Director of Patient Services, Office Administrator, and Celestina Cruz, RN- Vice President of Clinical Services. Date of Completion: 4/4/08 **Dawn Brill, RN** **Vice President of Regional Operations- North East**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L003	A. BUILDING _____ B. WING _____	11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES, INC.	1800 WHITE PLAINS ROAD BRONX, ny 10462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1306	Continued From Page 19	H1306		

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M. D.
Commissioner

January 17, 2008

Ms. Robert Silbering, Trustee/Chairman of the Board
Brooklyn CHHA Grantor Trust
President & Chief Executive Officer
Forensic Investigative Association, Inc.
230 Park Avenue, Suite 422
New York, NY 10169

Re: Family Care Certified Services
Provider # 337-7264
Survey Date: 11/5, 11/6, 11/7, 11/8, 11/9, 11/13/07

Dear Mr. Silbering:

Please be advised that the Plan of Correction relating to the recent Article 36, Medicaid/Medicare survey of your certified home health agency has been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies cited.

If you have any questions regarding this matter please do not hesitate to contact this office at (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis RN, MSN, CS
Program Manager
Home Health and Hospice Services
Metropolitan Area Regional Office

cc: Deborah Walsh, Administrator
Galina Sirota, Director of Patient Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERT SERVICES OF BROOKLYN QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS A standard recertification survey was conducted on 11/5/07, 11/6/07, 11/7/07, 11/8/07, 11/9/07, and 11/13/07 at Family Care Certified Services. Twenty five (#1-25) clinical records were reviewed. Ten (10) home visits were conducted for ten (10) patients #2, #3, #4, #6, #7, #8, #9, #10, #11, and #12. Ten (10) personnel files #1-10 were reviewed.	G 000		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure. This STANDARD is not met as evidenced by: Based on clinical record review, and agency personnel interview, the agency failed to ensure that home health aides employed by the agency possessed valid certification, references and physical assessments. This was evident for (1) one of (4) personnel records reviewed. (Employee #6) Failure to ensure home health aide certification requirements, employee references, and employee health assessments has the potential to place agency patients at risk for care to be provided by unqualified personnel:	G 118		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DPS | 1.3.08

/ ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that o safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		G 118	• Employee #6 was removed from the case and a replacement Home Health Aide was assigned.	11/13/2007
			• Two additional Home Health Aide Coordinators will be hired (one is currently in training) by January 31, 2008, in order to more closely monitor Home Health Aide profiles and certificates. A new profile request form was developed (attachment #1) and will be faxed to the licensed agency providing the Home Health Aide. No Home Health Aide will be permitted to work on a case until the profile is received, reviewed and approved by Family Care Certified Services.	1/31/2008
			• A new policy was written (attachment #2) and sent to all licensed vendor agencies (attachment #3). The policy will be initiated by January 15, 2008.	1/15/2008
			• Ten Home Health Aide vendor agencies per quarter will receive on-site surveys by the Clinical Care Manager of the department to review ten complete personnel files. Tool to be developed by December 31, 2007.	12/31/2007
			• Results will be submitted to the Performance Improvement department and results analyzed. First Performance Improvement quarter report due May 15, 2008. Ongoing surveillance planned quarterly.	5/15/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		G 143	• Patient #7 – On November 8, 2007 a PRN visit was made. An O_2 safety precaution poster was placed in the home. Instruction was given to the patient and caregivers and documented in the patient's record. The Home Health Aide Plan of Care was corrected to include O_2 safety and precautions.	11/8/2007
			• On November 15, 2007, the Performance Improvement monthly presentation on O_2 safety and precautions was conducted as already scheduled. A copy of the education material (attachment #4) was sent to all patients and clinicians.	11/15/200
			• During the November 29, 2007 case management meeting (attachment #5) the case managers were in-serviced regarding monitoring documentation of O_2 safety and precautions by the field staff.	11/29/200
			• During the December 20, 2007 case management meeting (attachment #6) planned monitoring of the Home Health Aide Plan of Care will be reinforced. A compiled list (done on November 20, 2007) of all patients receiving home O_2 therapy was given to the Performance Improvement department. A tool was developed (attachment #7) and will be used to monitor 50% of patients on O_2 therapy quarterly for one year. The first report is due on May 15, 2008.	12/20/200 11/20/200 12/12/200 5/15/200

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		G 143	• Patient #8 – On November 7, 2007 a PRN visit was made at the change of shift to supervise the care provided by the Home Health Aide. Documents were reviewed after the visit and the RN gave in-service to the aide in T + P and leg elevation.	11/7/2007
			• The November 20, 2007 and December 7, 2007 mandatory in-service of the field staff reinforced the agency policy regarding Home Health Aide supervision when dealing with 2 ½ hours shifts and supervision of night time Home Health Aides (attachment #8). A memo was sent to all field staff on December 17, 2007 reinforcing the policy (attachment #9). The December 20, 2007 case manager meeting will reinforce the policy (attachment #6).	11/20/2007 12/7/2007 12/17/2007 12/20/2007
			• A chart review tool was developed (attachment #10) and will be utilized by the Performance Improvement department to monitor 25% of patients with night time Home Health Aides. The first report will be due May 15, 2008 for the first quarter project and will continue with information for the second quarter of 2008 and reassessed.	12/12/2007 5/15/2008

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		G 143	• Patient #8 – On November 6, 2007 case manager called Dr. Asbel to clarify medication changes as observed during the visit. The medication sheet was updated and physician's verbal orders were sent and signed (attachment #11). The Community Health Nurse was counseled on (attachment #12) November 6, 2007 and a supervisory visit was made to follow up on medication assessment with management.	11/6/2007 11/6/2007
			• Field Community Health Nurses were in-serviced on November 20, 2007 and December 7, 2007 (attachment #8) regarding medication management and assessment and the importance of reporting changes to the case manager and/or the MD and documentation of same. A memo was also sent (attachment #9) dated December 17, 2007 reinforcing Family Care Certified Services policies on medication management (attachment #13); a medication management tool was sent with the memo.	11/20/2007 12/7/2007 12/17/200
			• The case management staff will be in-serviced at the December 20, 2007 meeting regarding the importance of asking the Community Health Nurses if there were any medication changes during the client case conference. A tool will be created by December 31, 2007 to monitor compliance via home visits by supervision; ten patients per quarter will be monitored. Data will be submitted to the Performance Improvement Department for analysis. The first quarter data report is due May 15, 2008.	12/20/200 12/31/200 5/15/200

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		G 143	• Patient #17 – Case manager was counseled on November 12, 2007 regarding proper documentation of discharge planning and conversion follow up (attachment #14). As of December 14, 2007 patient's M11Q was sent to MD. The M27R is completed. • The December 20, 2007 case management meeting will reinforce proper discharge planning protocol and documentation requirements (attachment #6). A tool was developed to monitor compliance (attachment #15). • The Performance Improvement department will perform chart reviews. Reviews will consist of twenty-five discharge charts per quarter. The first report is due May 15, 2008.	11/12/2007 12/14/2007 12/20/2007 5/15/2008

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
		G 143	• Patient #14 – The Physical Therapist was counseled regarding proper documentation of discharge (attachment #16). A summary note was done on the patient and added to the patient's medical record (attachment #17). • An in-service is scheduled for the end of January 2008 for all therapy staff. Agenda to include proper discharge planning. Documentation and use of discharge summary note to reflect summary of care and goals met. A memo was also sent on December 12, 2007 reinforcing documentation requirements stated above (attachment #18). • At the December case management meeting (attachment #6) proper discharge planning in conjunction with all service will be reinforced. A tool will be developed by the Rehabilitation department supervisor to monitor compliance with discharge planning and use of discharge summary note. • The Performance Improvement department will monitor twelve discharge charts per quarter times two quarters. First Performance Improvement report is due May 15, 2008.	1/31/200 12/12/200 1/15/200 5/15/200

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		G 143	• Patient #20 – Physician's MD order dated June 18, 2007 was signed (attachment #19). Case manager was counseled regarding the importance of obtaining signed MD orders in a timely manner (attachment #20).	6/18/2007
			• Home Care Case Manager meeting is planned for December 20, 2007. All case managers to reinforce the importance of obtaining MD verbal orders in a timely manner (attachment #6). Tool was developed to monitor submission of signed MD verbal orders (attachment #21).	12/20/2007
			Performance Improvement will review fifty charts per month every quarter. First report due May 15, 2008.	5/15/2008
		G 158	• Patient #8 – The Community Health Nurse was counseled on November 6, 2007 (attachment #12). Clinical supervisor conducted a supervisory visit on November 9, 2007 to reinforce wound procedure with Community Health Nurse and check on patient's clinical status - no wound infection observed. Community Health Nurse will receive an additional supervisory visit by clinical supervisor before December 31, 2007.	11/6/2007 11/9/2007 12/31/2007
			• A memo was sent to all field Community Health Nurses on December 12, 2007 (attachment #9) reinforcing wound care policy and proper wound technique.	12/12/2007
			• A mandatory in-service was conducted on November 20, 2007 and December 7, 2007 (attachment #8) to reinforce wound procedure.	11/20/2007 12/7/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337264	A. BUILDING _____ B. WING _____	11/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY CARE CERTIFIED SERVICES OF BROOKLYN/QUEENS	405 91ST STREET BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
		G 158	• Patient #8 (continued) – A tool to monitor compliance with wound care will be developed by December 31, 2007. Ten home visits will be made quarterly by the clinical supervisor using the tool to monitor wound procedure compliance. The data will be submitted to the Performance Improvement department. Data will be collected for two quarters. First report due May 15, 2008.	12/31/20 5/15/20

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines
Commissioner

Wendy E. Saunders
Chief of Staff

February 12, 2008

Mr. Kenneth P. Kilroy
VP/Administrator
Progressive Home Health Services, Inc
132 West 31 Street, 7th Floor
New York, NY 10001

Re: Response to Plan of Correction
Survey Date: February 16, 2007
License: 1348L001

Dear Mr. Kilroy:

Please be advised that the plan of correction relating to the recent Article 36, survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verity the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

New York State Department of Health

STATEMENT OF OEFICIENCIES PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
PROGRESSIVE HOME HEALTH SERVICES. INC.	132 WEST 31STSTREET. 7TH FL. NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A full survey and complaint investigation (#07-01-50071) was conducted on 02/15/07 and 02/16/07. In addition, off-site telephone interviews were conducted on 2/21/07 due to the complaint investigation. During the survey five (5) patient care records (identified #1 - #5) and eleven (11) personnel records were reviewed (identified #1 - #11).	H 000	766.5(b)(4) Clinical Supervision (b) all staff delivering care in patient homes are adequately supervised. Kind Care has instituted the following to better address the adequacy of clinical supervision regulation: Home attendants will continue to be oriented to the Plan of Care by Kind Care Nursing Staff. A replacement home attendant is considered any home attendant that has not serviced the patient within six (6) months.	
H 620	766.5(b)(4) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (4) plans of care are revised as needed and changes are reported to the patient's authorized practitioner, other staff providing care to the patient, and other agencies which authorize payment for services, as appropriate and necessary. This Rule is not met as evidenced by: Based on clinical record review and interviews, the agency failed to supervise and ensure that the aide plan of care (developed by the skilled nurse to direct the paraprofessional staff in the care and services to provide to the patient) is complete, accurate and reviewed/revised as necessary, to address changes in the patient ' s condition. This was evident for (1) of five (5) clinical records reviewed. Failure to ensure complete and accurate aide	H 620	A schedule of Kind Care Nursing Staff on duty has been developed to ensure that there is a nurse available at all times in the office and during off hours. Should the Kind Care Nursing Staff assigned be absent or out of the office, arrangements are made in advance to ensure coverage. Coordination staff is responsible for informing the Kind Care Nursing Staff of the replacement via a Replacement Orientation Form (Attachment A). The coordination staff will submit a Daily Replacement List (Attachment B) to the Data Entry Liaison for the replacements that the Kind Care Nursing Staff received. Once the Kind Care Nursing Staff completes the orientation, the Replacement Orientation Forms are given to the Data Entry Liaison. The Data Entry Liaison will then verify that a Replacement Orientation Form has been received for every patient on the Daily Replacement List. If there is a discrepancy, the Data Entry Liaison will inform the Kind Care Executive Director or the Assistant Director of Field Operation who will then ensure that a replacement orientation is conducted for the patient in question.	06/25/07 Accepted 2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Eleanor Halley — ADMINISTRATOR/VP — 2/5/08

New York State Department of Health

STATEMENT OF OEFICIENCIES O PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
PROGRESSIVE HOME HEALTH SERVICES, INC.	132 WEST 31STSTREET. 7TH FL. NEW YORK, NY 10001

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE OATE
H 620	Continued From Page 1 Plan of Care that directs the paraprofessionals in caring for patient, has the potential for the patient to receive inadequate /inappropriate care and poor patient outcomes. The finding is: Patient#5 was admitted to the agency on 04/06/05 with diagnoses of Hypertension, Glaucoma, Dementia, Coronary Artery Disease, and Depression. The clinical record documents that the patient was discharged from the agency on 11/7/06. The Medical Request for Home Care (Form M-11q) dated 11/30/05 documents that the patient required assistance with personal care and housekeeping services. The clinical record documents that the patient received home attendant services seven days/week twenty-four hours/day. The agency provides home attendant services under contract with the New York City Department of Social Services of the Human Resources Administration. The Nurse ' s Assessment Visit Report dated 9/20/06 documents that patient was "confused"; had "impaired judgement, needed prompting/cueing with all activities", was "incontinent of bladder/bowel", and required "total assistance" with personal care. The record documents that the patient could "not be alone in the home." The aide Plan of Care (POC) dated 9/20/06 documents that the patient required total assistance with personal care needs and that the patient was on a "low salt puree diet". The aide POC also directs the home attendant to " report changes. "	H 620	The Replacement Orientation Form is filed in the patient's chart by the Data Entry Liaison. All home attendants are being advised through initial orientation and at inservices that if they are working as a replacement aide and if they do not hear from the Kind Care Nursing Staff within an hour of their start time, they should contact the office immediately and request to speak with the Kind Care Nursing Staff. The Kind Care Executive Director will be responsible for implementing this Plan of Correction. 766.5(b)(4) Clinical Supervision (4) Plans of Care are revised as needed and changes are reported to other agencies which authorized payment for services. All Kind Care Nursing Staff have received additional training from the Assistant Director of Nursing, in a clinical meeting and during ongoing individualized sessions. Emphasis has been place on the review of medication and body systems during patient assessments. When there is a change in the patient's condition or medication, the Plan of Care must be revised to reflect this change. The Plan of Care is reviewed during every quarterly patient visit. Each Kind Care Nursing Staff must sign off that the Plan of Care has been reviewed. Where there is no change, the Kind Care Nursing Staff will write "no change" and sign the Plan of Care. The visit paperwork is then submitted to the Assistant Director of Nursing or designee for a clinical review.	11/05/07 11/05/07 06/25/07 06/25/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES, INC.	132 WEST 31STSTREET, 7TH FL. NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From Page 2 The Client Notes dated 11/07/06 documents that the home attendant reported on 11/06/06 that the patient "died in the bed." In a complaint received by the Department of Health (DOH), the complainant alleges that the "Home Attendant (HA1) was trained by the previous aide (HA2) and the family to add Thick-it to Ensure when feeding the patient. HA1 did not add the Thick-it which resulted in the patient ' s dead due to aspiration of Ensure." The complaint also alleges that a family member "came home to find" the patient " sitting in a chair dead. " . HA1 was present and stated that the patient " had been cool for a while. " The complainant stated that it was the family member that called 911. On 01/25/07, the Medical Examiner from the New York City Medical Examiner ' s Office notified DOH that the patient ' s "cause of death was aspiration of Ensure." On 02/16/07 at 2PM, the skilled nurse (SN), who supervised the aide and prepared the aide plan of care was interviewed and stated that the patient was "on puree diet including Ensure". However, the SN was unable to state whether the patient was on aspiration precaution or if the aide added Thick-It to the patient ' s juice and Ensure. The Clinical review record including the aide plan of care did not document that the patient ' s diet included Ensure. A telephone interview was conducted on 02/21/07 at 1PM with the Assistant Director of Nursing, Incident Supervisor, and the Home Attendant (HA1) who was present in the home at the time of the patient ' s death. The HA1 stated that she was the "replacement aide" who	H 620	The Assistant Director of Nursing or designee will review the paperwork to ensure that the Plan of Care matches the Kind Care Nursing Staff assessment, and that the Plan of Care reflects the Scope of Tasks for a home attendant. If there is a discrepancy, the Assistant Director of Nursing or designee will contact the Kind Care Nursing Staff. Should changes be necessary, the Kind Care Nursing Staff will be responsible for updating the Plan of Care and ensuring that the patient and home attendant are aware of the changes. A revised Plan of Care is left in the patient's home for home attendant use. The Assistant Director of Nursing or designee will continue to reinforce with the Kind Care Nursing Staff the importance of reporting and recording changes in patient's status. This will occur at the next quarterly clinician meeting. In addition, during the Annual Regulatory Compliance Inservice held in April 2007 - June 2007, special emphasis was placed on the home attendants calling in and reporting changes. The home attendants are being encouraged to report any requests from family members, patients, other nurses or doctors involved with their patient that would involve a task that is not part of the Plan of Care. This is being reinforced at every inservice session held throughout the year and with every clinical contact. The Assistant Director of Nursing will be responsible for this corrective action and ensuring continued compliance.	10/01/07 07/10/07

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
PROGRESSIVE HOME HEALTH SERVICES. INC.	132 WEST 31STSTREET. 7TH FL. NEW YORK, NY 10001

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE OATE
H 620	Continued From Page 3 provided service on 10/29/06, 11/04/06, 11/05/06, and 11/06/06 and the patient required total care which included turning and reposition and feeding the patient (who was on a liquid/puree diet including Ensure.) HA1 stated that she "did not receive any instructions from the agency regarding the aide Plan of Care" nor did she receive "instructions regarding adding Thick-it to liquids including Ensure." In the Employee Statement dated 2/21/07, HA1 reported that " on 11/06/06 she "gave the client a bed bath in the morning and turned the client every two hours. The client was fed a liquid puree diet that was prepared by the client ' s daughter. The client may have used a sippy cup to drink her meals. The client did not choke or spit up the meal. " HA1 reported that she "raised the bed" when she fed the client. "About an hour after turning the client, the daughter came to check on her mother. When the daughter touched her, she stated that her mother felt cold. 911 was called." On 2/21/07 at 3PM with the Administrator, Director, Assistant Director of Nursing, and the regularly assigned Home Attendant (HA2) were interviewed. HA2 stated that she provided care to the patient from April 2005 to November 03, 2006 and the patient "required total care including feeding". She further stated that the patient was on a "liquid puree diet including Ensure" and she "started adding Thick-it to the patient ' s juice and Ensure after the patient ' s was hospitalized in October 2006." HA2 stated that "after the hospitalization, the patient ' s daughter said that the doctor recommended a Gastric Tube (G-Tube) insertion for the patient and that the family had refused." HA2 added that since the family refused to insert the G-Tube, the doctor ordered that the patient be	H 620	Page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES. INC.	132 WEST 31STSTREET. 7TH FL. NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From Page 4 placed on Thick-it due to the " patient ' s swallowing problem " which included choking and coughing while eating. HA2 added that the daughter was given a packet of Thick-It at the hospital and later purchased additional packets. HA2 said that the patient ' s daughter gave instructions on how to use the Thick-It and she complied by adding Thick-It to the patient ' s juice and Ensure. HA2 stated that she also instructed to HA1 on how to use Thick-it. In the Employee Statement dated 02/21/07 (received by DOH on 02/26/07), HA2 reported that " most of the time she fed the client and it was an all day process. The client was fed spoonfuls while sitting up in bed. " HA2 also reported that she advised the replacement aide (HA1) on the patient ' s needs. The clinical record documents that the patient was hospitalized on 10/10/06. The clinical record titled Client Notes dated 10/12/06 documents: " client ready for hospital discharge 10/13/06 at 11AM ...P/U (pick-up). " The record failed to document any communication with the hospital regarding any changes in the patient ' s plan of care. The clinical record also lacked documentation that HA2 reported any changes to the agency after the patient was discharged from the hospital. Additionally, a review of the Replacement Flow Sheet which documents supervision of replacement HA failed to document that the agency provided any supervision to HA1. On interview of 02/20/07, the Assistant Director of Nursing (DON) stated that it was the responsibility of the hospital to inform the agency of any changes in the patient care that required a revision in the plan of care. The Assistant DON added that hospital did not inform the agency of	H 620	Page intentionally left blank.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES, INC.	132 WEST 31STSTREET..7TH FL. NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From Page 5 any changes.	H 620		
H 718	766.6(a)(8) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (8) documentation of accidents and incidents. This Rule is not met as evidenced by: Based on review of clinical records, agency policy and procedure, and interviews with agency staff, the agency failed to ensure that an incident was investigated with a completed report. This was evident for one (1) of five (5) clinical records reviewed (Patient #5). Failure of the agency to ensure the documentation of accidents/incidents places the patients at risk for receiving unsafe and poor quality of care. The finding is: Patient#5 was admitted to the agency on 04/06/05 with diagnoses of Hypertension, Glaucoma, Dementia, Coronary Artery Disease, and Depression. The Client Notes dated 11/07/06 documents: " 11/6/06 @ 6PM - aide called to report that the client passed away half hour ago. She said the police and the family are there. Aide said the client passed in her bed. " The clinical record documents that the patient received home attendant services seven days/week twenty-four hours/day.	H 718	766.6(a)(8) Patient care record 766.6 Patient care record (a) the agency shall maintain a confidential record of each patient admitted to care to include: (8) documentation of accidents and incidents. All staff are responsible for, and encouraged to, report incidents. Kind Care will be using the same incident policy followed by Progressive Home Health Services, Inc. All Kind Care Staff, including off hours staff, were retrained on the incident policy to ensure appropriate reporting and documentation of all incidents, including deaths. The Kind Care Executive Director and the Incident Supervisor will be responsible for this corrective action and ensuring continued implementation. The Senior Vice President/Chairman will provide the information identified in this Plan of Correction to Kind Care's Quality Improvement Committee and to the Governing Board for review and approval.	06/25/07 11/01/07

New York State Department of Health

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1348L001	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES, INC.	132 WEST 31STSTREET, 7TH FL. NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 718	Continued From Page 6 The agency policy/procedure for Incidents documents: " Documentation of the situation will be entered onto the Attendance System and an Incident Report will be completed, as necessary. All home health employees will provide interview and/or statement as requested. " The " Incident Log" lacked any documentation that an incident report was completed or that agency employees were interviewed. On interview of 2/16/07 2PM, the Director stated that the agency did not complete an incident report because it was determined that "one was not necessary in this case."	H 718	Page intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	R 02/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS A Follow-up and Complaint Survey was conducted at Americare Certified Special Services on 02/11/08-02/13/08. Twelve (12) clinical records were reviewed and identified as Patients #1 - #12. Five (5) home visits were made to Patients #1, #2, #5, #6 and #7. 484.30(a) DUTIES OF THE REGISTERED NURSE	{G 000}		
{G176}	The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record review, home visit and staff interview, the nurse failed to ensure coordination of services regarding the administration of prescribed medications between the Adult Care Facility (ACF) staff and the agency staff in one (1) of five (5) home visits (Patient #1). The agency's failure to ensure effective coordination of service resulted in the patient not receiving the required medication and places all patients at risk for poor quality care. Findings are: Patient #1 was admitted to the agency on 04/28/05 with diagnoses of Chronic Airway Obstruction, Schizophrenia, Hypertension and Esophageal Reflux.	{G176}	The nurse in question was previously disciplined for failure to perform her expected duties and appropriately assess patient's medical needs. She was placed on an action plan in December and informed if there is not a "noticeable" improvement she would be discharged at the end of February. Her last date of employment is Feb. 29, 2008. (See attachment # 1 - HR policies regarding progressive discipline and termination). All residents in Adult Care facilities have rights guaranteed to them under federal and state law. These rights include the resident's right to self-administration of medication, if the resident requests to self-administer drugs, and the physician certifies it is safe (in writing). The Americare nurse will assess, supervise, direct and instruct the patient under the physician's plan of care (485). The Americare nurse will review (based on the frequency of nursing visits) the patient's/facilities medication administrative record (MAR) with the facilities Med-Tech or other designated individual for medication dosage too high/low, medication interactions, side effects, allergies, therapeutic benefits, administration issues including schedule and route, compliance with self-administration and adequate supply. (See attachment # 2 Medication Review Form) In accordance to Federal regulations independent self-administration occurs when a patient/resident is independently able to directly apply a legend drug or controlled substance by ingestion, inhalation, injection or other means. In licensed Adult Homes, self-administration may include situations in which an individual cannot physically self-administer medications (i.e., patient with arthritic hands, may require assistance to open a cap on a medication bottle) but can accurately direct others. Americare Nurses, as practitioners, will determine if self-administration of medications with assistance is appropriate. This will be achieved by direct observation and questioning.	Feb. 29, 2008 Westbury February 21,2008 & Suffern by March 27, 2008

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

TW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRINTED: 02/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	R 02/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
{G 176}	Continued From page 1 The Plan of Care (POC) for 12/14/07-02/11/08 ordered Skilled Nurse (SN) twice daily for sixty (60) days for nebulizer treatment. The POC also ordered Combivent two (2) puffs inhalation two (2) times daily self administered and prn (as needed). The clinical record contained a "Supplemental Physician Order" dated 01/04/07 ordering Combivent inhaler two (2) puffs TID (three times daily), a fourth dose can be given PRN (as needed). The record contained a subsequent order dated 01/14/08 ordering Combivent two (2) puffs two (2) times a day – self administer. A Home Visit (HV) was conducted on 02/12/08 to the patient's residence at the ACF. During the visit, the surveyor interviewed the patient regarding the usage of the Combivent Inhaler. The patient stated he "does not use the inhalers". Review of the ACF's Medication Administration Records (MAR) for January 2008 listed the Combivent and documented "Pls (please) see at the back". Review of the back of the MAR failed to document information regarding the Combivent. The February 2008 MAR lists the Combivent with no indication of whether the patient received the medication. During the HV on 02/12/08 at 11:10 AM, the nurse was observed performing a clinical assessment of the patient. The nurse failed to evaluate the patient on the usage of the Combivent inhaler. The nurse was observed administering a nebulizer treatment to the patient. Review of the nursing visit reports for visits of 01/01/08 –02/06/08, the nurse consistently	{G 176}	Certified Home Health Aides in a community setting, and non-practitioners (Med Techs) in the Adult Home may assist the **"self-directing"** patient/resident in the self-administration of their medications as follows: • Reminding or coaching the individual to take their medication, • handing the medication container to the patient, • opening the medication container, using an enabler, or • placing the medication in the hand of the patient/resident. The patient/resident must be able to put the medication into his or her mouth or apply or instill the medication. The patient/resident does not necessarily need to state the name of the medication, intended effects, side effects, or other details, but must be aware that he/she is receiving medications & why (i.e., this blue pill is for my blood pressure and I take 1 tablet in the morning). Assistance may be provided with pre-filled insulin syringes. Assistance is limited to handing the pre-filled insulin syringe to a patient/resident. The patient/resident retains the right to refuse medication. In the event a patient refuses medication the patient's physician will be notified by the Americare Nurse. Self-administration of medication occurs when the resident assumes the responsibility for taking the right medication at the right dose, via the right route, at the right time, and for the right reason. Americare CSS nursing staff function as educators and supervisors. The responsibility for storage, documentation of the administration of the medication on the MAR, and re-ordering is between the resident and ACF staff. The nurse will notify the facility Administrator and MD if there is a delay in ordering medications and/or other medication issues. If an patient/resident cannot safely self-administer medication or self-administer with assistance and/or cannot indicate an awareness that he or she is taking a medication, then the medication must be administered to the patient/resident by a person legally authorized to do so (Med Tech) or by the Americare Nurse. TN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	R 02/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES –SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
{G 176}	Continued From page 2 Documented the patient's lung status as "wheezing" in both lungs and "Albuterol Nebulizer" treatments administered. The nursing visit reports lacked documentation of the patient's usage of the Combivent Inhaler as prescribed by the physician. The visit reports lacked documentation that the physician was notified of the patient not taking the Combivent Inhaler. Further review of the agency's Medication Profile lacked documentation of the corrected frequency of Combivent Inhaler. The Medication Profile dated 01/04/08 listed "Combivent Inhaler 2 puffs TID (three times daily) and a fourth dose to be given prn (as needed) in between or after standing dose" yet the Supplemental order dated 01/14/08 ordered the Combivent two (2) times a day. During interview with the agency's supervisor on 02/13/08 at 10:15 AM, the supervisor acknowledged the findings. The agency continued to fail to ensure effective coordination of services between the ACF staff and the agency's nursing staff to provide the medications ordered for this patient Chronic Airway Obstruction and documented wheezing.	{G 176}	When there is a conflict in orders or an order is not clear or complete, the facility's policy and procedure on contacting the appropriate health professional is to be followed. All medications discrepancies and/or conflicts will be brought to the physician's immediate attention by the Americare Nurse. **Responsible Person:** Americare CSS Nurse in the ACF is responsible for surveillance of medication administration . The Supervisor/DPS for each branch is responsible for oversight of the RN. Attachments reviewed Unacceptable 3/6/08 TN The plan lacks documentation of staff education and a system to monitor the effectiveness of the plan	
{G236}	REPEAT DEFICIENCY FROM 12/27/07 SURVEY 484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of	{G236}	Americare CSS has a computerized tracking system to track nursing visits. Those nurses that have not submitted notes within 7 days of the date of visit will be notified to come into the office. Paychecks of frequent offenders will have to be picked up in the Westbury office and will not be released till the documentation is complete in accordance Clinical Record Policy 484.48. Americare CSS will ensure that the nursing staff initiates the POC and revises the POC as needed to meet patient/resident needs. Americare CSS will provide as in-depth in-service to all ACF nurses	Feb. 22, 2008 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	R 02/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES SUB-UNIT	900 MERCHANTS CONCOURSE SUITE LL-15 WESTBURY, NY 11590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
{G 236}	Continued From page 3 physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on the agency's Plan of Correction, the completion date for the corrective actions for this deficiency is 04/14/08. Therefore, the agency could not be found in compliance with this regulation.	{G 236}	regarding use of the Medication review form, Pharmacology, and Behavioral Health Assessment no later than March 27, 2008. Americare CSS supervisors and/or DPS will review a minimum of 10% of each Adult Care facility patient clinical records on a monthly basis. Based on the findings ongoing education will take place and the audit results will be placed in the nurses personnel file to be reflected on their annual performance evaluation. **Responsible Person:** The Scheduler/Office Manager in each branch is responsible for tracking of nursing visits on a weekly basis. The Clinical Supervisor/ Manager &/or DPS for each branch is responsible for oversight of the nurses. Americare CSS Governing body will ensure that the required education and in-services take place and the Agency's have the continued support to resolve all identified deficiencies and prevent any reoccurrences of deficient practices.	March 27, 2008 April 14, 2008

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines
Commissioner

Wendy E. Saunders
Chief of Staff

March 12, 2008

Ms. Nancy Hahn
Administrator
Americare of New York City
205 Kings Highway
Brooklyn, NY 11223

Re: Response to Plan of Correction
Survey Date: December 5, 2007
License: LC0423A

Dear Ms. Hahn:

Please be advised that the plan of correction relating to the recent Article 36, survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verity the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

lew York State Department of Health

TATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments Full Survey was conducted at Americare of New York City on 12/5/07. Six Patient Care Records were reviewed and are identified as Patients #1 to #6. Six Personnel Records were reviewed and are identified as Employees #1 to #6. The Policy and Procedure manual, Federal Tax ID, Home Health Aide Training Quality Improvement/Quality Assurance Committee Meeting Minutes, Governing Authority Meeting Minutes, Complaint Log and Admission Packet were reviewed. An observation of a HHA training class was done.	H 000	(See H204 Paragraph #1) (A) Director of Quality Assurance presented and discussed revised policies and procedures for grievance / complaints and patient bill of rights, during a performance improvement meeting on January 11, 2008. (See enclosed attachment) (A) Policies were approved by the Administrator and were given to the Department Directors and Managers to disseminate to staff for orientation and implementation. Information was disseminated through one or more of the following: printed, electronic, and presentation materials. (A) Minutes of PI meeting was sent to the Governing Board for effective planning, directing, implementing, coordinating, and monitoring care and service activities. The revised policies and procedures will be reiterated to the Governing Body on 3/12/08 during our Quarterly Professional Advisory Committee (PAC).	1/11/08
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges; (3) be advised before care is initiated of the	H 204	(A) The Quality Management Customer Relations Representative translated our Americare Inc. patient bill of rights in several languages (English, Spanish, French, Creole, Russian, etc.) in order to accommodate diversified patients served. (See H204 Paragraph #2) (1) The revised Bill of Rights is available to the patient during care of care and initial nursing visits. Americare Inc. patients are informed of their rights, and they have the right to exercise such rights. This measure was put in place to ensure that deficient practices do not recur.	

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Nancy Hahn — Administrator — 3/4/2008

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	766.1(a)(1) Patient rights	H 204	(See H204 Paragraph #2) (1) The development of a Quality Management Continuous Improvement Program and strategy to promote patients' rights and responsibilities has to be carefully prepared by Director of Quality Assurance. (See H204 Paragraph #2) (1) The processes and structures of Quality Management Continuous Improvement Program will work toward the following objectives: • Educating the staff on patient rights • Creating positive outcomes • Efficient and effective services • Complying with standards (See H204 Paragraph #2) (1) Clinical Manager is providing direct oversight of the Nursing Department and is effectively ensuring that every patient is given a Patient's Bill of Rights sheet with every initial visit and reviewed with the patient by the nurse. This measure was put in place to ensure that deficient practices do not recur for those patients found to have been affected by the deficient practice. (See H204 Paragraph #3) (2) Americare, Inc. provides a list of the charges for our private paying cases only. This list includes rates for R.N. initial visits, R.N. re-visits, HHA / PCA hourly rates and rates for 24-hour live-ins. These rates are given to the patient or guarantor prior to setting up an initial visit. The patient or guarantor is personally responsible for these charges. (See H204 Paragraph #4) (3) The cases that are not private paying are vendor generated. The vendors (Provider Relation and Case Managers) are responsible for supplying the patient with a listing or their services and all information on payments (including third party payor.)	Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X5) DATE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 1 extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient. (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to inform the patients of their right to be informed of any changes in information or services within 30 days. This was evident in (5) out of (6) patient care records reviewed (Patients # 2-6). Failure to provide the patient the right to be informed of change in information or services within 30 days of knowledge places the patient at risk for not being able to make decisions regarding their care in a timely manner. The findings are: The agency: " Patient Bill of Rights " documents the following information: " Every patient shall be given a statement of the services	H 204	(See H204 Paragraph #5) i) Carol Rizzuto, Contract Supervisor, assures that Americare Inc. patients receive financial information as followed: • Insurance information • Knowledge of charges not covered • Receiving information within 30 days verbally and in writing if Americare becomes aware of any changes in charges • Having access to all bills upon request However, if services are being provided thru a managed care vendor / agency (Guildnet, CCM Vera institute, Senior Health Partners, etc), it is their responsibility to provide financial information to the patient / client. (See H204 Paragraph #6) (ii) The Americare Inc. nurses, vendor Case Managers and Provider Relation staff are responsible for providing the patients with this information orally and in writing. (See H204 Paragraph #7) (4) 1/31/08 Administrator, Director of Quality Assurance and, Director of Patient Services revised our Licensed Home Health Services Information For Patient and Care Partner Booklet. The booklet was developed to provide patients and caregivers general information about Americare Inc., including available services to meet patient home care needs. The booklet will be ready for a mass patient distribution by 3/08. The department heads will monitor the booklet and updates will be provided as needed. (See enclosed attached booklet) (See H204 Paragraph #7) (4) Clinical Manager is effectively ensuring that that Nursing Department nurses are distributing and explaining the patient bill of rights, forms, care plan, patient booklet, patient related information and services to all patients. (See H204 Paragraph #7) (4) The vendor's (Guildnet, CCM Vera institute, Senior Health Partners, etc.) Case Manager is responsible for fulfilling the patient's needs, i.e. PT, OT Speech Therapy, etc. The vendor will fax authorization request. for nursing and HHA services only. All Americare, Inc. personnel wears I.D. Badges and identify themselves and as well as the reason for their visit.	Ongoing Ongoing Initiated 1/31/08 - Expected Completion 3/08

New York State Department of Health

EMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 2	H 204	(See H204 Paragraph # 8) The record reviewed during 12/05/07 survey was contracted (Guildnet, CCM, Vera institute, Senior Health Partners, etc.) therefore it is the vendor's Case Manager's responsibility to inform their clients of any change to their services i.e. frequency of nursing and HHA. (See H204 Paragraph # 8) Based on the contractual agreements, when we coordinate and arrange Home Health Aides and / or a nurse for our client the patient is informed of any changes in information or services within 30 days. (See H204 Paragraph # 9) The record reviewed during the audit was a contracted (Guildnet, CCM Vera institute, Senior Health Partners, etc.) therefore it is the vendor's Case Managers and Provider Relation staff's is responsibility for providing the patients with this information. Based on the contractual agreements, when we coordinate and arrange Home Health Aides and / or a nurse for our client the patient is informed of any changes in information or services within 30 days. (See H204 Paragraph # 10) Only the private paying patients are provided with a listing of the services available and the fee schedules. These are discussed with the patient and/or the guarantor before accepting the case. (See H204 Paragraph # 10) In cases where it is a vendor case, is the responsibility for that vendor staff or Case Manger to notify the patient of available services. Americare Inc. can only provide services with authorizations from vendors.	12/10/07 - Ongoing Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 2 available by Americare and related charges and billing mechanisms. Each patient or responsible person is informed of and agrees to a written reimbursement/billing mechanisms. Each patient or responsible person is informed of and agrees to a written reimbursement /billing plan prior to the initiation of care and has the right to examine, question and receive a full explanation of any bill, regardless of payment source...." There is no documented evidence of the agency agreeing to notify the patient as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. On 12/5/07 at 12:17 PM the Director of Patient Services was interviewed and stated: " it will go into effect in January. "	H 204	(See H204 Paragraph # 11) We currently have a Licensed Home Health Services Information For Patient and Care Partner Booklet. The booklet was developed to provide patients and caregivers general information about Americare Inc., including available services to meet patient home care needs. The booklet will be ready for a mass patient distribution by 3/08. This measure was put in place to ensure that deficient practices do not recur for those patients found to have been affected by the deficient practice. (Ans. for H204 paragraph 12 See H204 Paragraph # 7)	Initiated 1/31/08 - Expected Completion 3/08
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal.	H 222	(See H222 Paragraph #1) (a) Americare Inc. recognizes the vital nature of staff and their contribution to our agency. Their input and involvement is essential in order to get the best results from the service and any improvement activity. (See H222 Paragraph #1) (a) Americare Inc. currently have policies and procedures and avenues for patients / clients and families to address the rights of clients, obtain explanations, address grievances and serve as an advocate for clients who feel that their rights have not been properly respected. The Director of Quality Assurance conducts continuous monitoring of the process. (See enclosed attachment)	Currently

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 3	H 222	(See H222 Paragraph #1) (Continuation of (a)) Americare Inc. assures that effective leadership, procedures, communications, hiring practices, and many other activities also help improve performance. The best decisions on how to achieve performance improvement have been based on the value that different approaches. Which approach has been most successful depends on the specific objectives to be achieved. In order to accomplish goals and objectives, (a) The Administrator has developed a series of organizational structures as outlined below: (a) Director Level Meetings: Directors Americare Inc. meet weekly to review major system developments, to formulate policy recommendations, and facilitate program planning, strategic planning and continuous quality improvement regarding the rights of the patients. (a) Middle Management Meetings: These meetings meet monthly are largely Home Health Aide (HHA) and patient focused, but also serve to identify problems in the functioning of the service system. Identified systems problems are referred to the appropriate committee for review and action (a) Staff General Meetings: These meetings meet every six months focuses on staff's involvement with continuous quality improvement within, Americare Inc.	Continuous

New York State Department of Health

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 3	H 222	(See H222 Paragraph #2) (8) Our Americare Inc. patients have the right to voice grievances without fear of recrimination. The Quality Management Department Grievance Coordinator , QM Liaison and Director, investigate complaints made by a client/family regarding treatment or care that is furnished, or fails to be furnished. A grievance / complaint can be made by contacting our Care Coordinator at 718-434-5100. (8) The Director of Quality Assurance will perform the following systemic changes: randomly checking, and ensuring that process for improvements are working properly. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. (See H222 Paragraph #2) (Continuation of (8)) The Coordinator is currently documenting both the existence of the complaint and the resolution of the complaint. If the patient feels that satisfaction action has not been taken they may contact our newly hired Grievance Coordinator for further assistance. Patients are advised in writing via patient booklet, patient bill of rights as well as verbally by the staff to contact the New York State Department of Health and the Joint Commission on Accreditation of Healthcare Organizations if their complaint was not addressed properly by an Americare.Inc. staff or administration.	12/06/07 Currently

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 4	H 222	(Continuation of H222 Paragraph # 4) The Americare inc. staff was given the correct number for patient related complaints. Furthermore, the Clinical Manager, Nursing Department Case Managers and Field Nurses assures that hot line complaint numbers are given to all patient during their initial nursing visit. Numbers provided by the nurses includes: • Americare Contacts • Department of Health Complaint # • Joint Commission Complaint #	Immediately implemented
			(See H222 Paragraph #5) Unfortunately the State Department of Health Phone Number 212-268-7001 provided is disconnected. (See H222 Paragraph #5) A mass mailing was conducted by the Administrative staff and sent to 2,084 Americare Inc. patients with the correct contact information. The letter advised patients to contact the State Department of Health Phone Number at 1-800628-5972 or **212-417-5888**. The State Department Of Health Hours of operations are 8:30am-4: 30pm, Monday through Friday, excluding State and federal Holidays. (See enclosed attachment)	Immediately implemented
			(See H222 Paragraph # 6) Our Licensed Home Health Services Information For Patient and Care Partner Booklet currently has the correct information for the New York State Department of Health. This measure was put in place to ensure that deficient practices do not recur for those patients found to have been affected by the deficient practice.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 3 This Rule is not met as evidenced by: Based on record review and interview, the agency failed to provide the patients with the correct information to contact the New York State Department of Health. This was evident for (2) out of (6) patient care records reviewed.(Patients # 3 and 4) Failure to provide the correct telephone number to the patient places the patient at risk for not being given the opportunity to lodge a complaint with the New York State Department of Health and it violates the patient ' s right. The findings are: The agency: " Patient Complaint/ Grievance Procedure " documents the following information: " You may express complaints about the care and services provided and have Americare investigate such complaints. The State Department of health Phone Number is 212-268-7001. The State Department of Health Hours of Operation are 8:30_4:30 P.M., Monday through Friday, excluding State and federal Holidays. The documented telephone number is not the correct contact information for the New York State Department of Health. The patient care records for Patient #3 and #4 ' s have the forms with the incorrect information. On 12/5/07 at 4:07 PM, the Director of Patient Services, stated: "....everyone will get that information as of January 1st."	H 222	(See H222 Paragraph # 3) Immediately implemented on 12/11/07 by Administrator, Quality, Nursing and Marketing Department. Patient information letters, manuals and materials now includes the following: * (See H222 Paragraph # 3) The public may contact the State Department for patient complaints at 1-800 628-5972 or 212-417-5888. The State Department Of Health Hours of operations are 8:30am-4: 30pm, Monday through Friday, excluding State and federal Holidays. (See H222 Paragraph # 3) They may also contact Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about a Joint Commission-accredited health care organization by either calling 1/800-994-6610 or emailing complaint@jcaho.org. (See enclosed attachment) (See H222 Paragraph # 3) Our patient letters were translated into several languages (English, Spanish, French, and Russian) and were mailed to 2,084 Americare Inc. patients. (See H222 Paragraph # 3) Our newly hired 2/11/08 Quality Management Customer Relations Representative ensures continuous compliance by tacking and mailing the letter to new patients. This measure is put in place to ensure that deficient practices do not recur. (See H222 Paragraph # 3) Clinical Manager is ensuring the receipt by every patient. Every patient is asked upon a revisit if they have received it. If not, then the nurse will hand out a packet and request a signature on an orientation form, which confirms receipt of it. This signature page will be placed in the pt's chart. Every initial visit will have this packet as part of the initial paperwork. This way every one of our patients is supplied with this info. (See H222 Paragraph # 4) All current patients have been sent a letter signed by administration with the correct telephone number for Department of Health. All future patients will receive this documentation during start of care, with the correct numbers.	12/11/07

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From Page 4	H 222	(See H222 Paragraph # 7) Currently changed, as documented above.	Immediately implemented
			(See H222 Paragraph # 8) 12/10/07 Patient letters informing Americare inc. patients with the correct contact information (hotline number, email, and mailing address) on contacting the New York State Department of Health and the Joint Commission on accreditation of Healthcare Organizations was translated in several languages. (English, Spanish, French, and Russian) and was mailed to 2,084 Americare Inc. patients. The revised Information For Patient and Care Partner Booklet will be ready for a mass patient distribution by 3/08.	12/10/08

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 4	H 404	(See H404 Paragraph #1)	
H 404	766.3(b) Plan of care 766.3.Plan of care. The governing authority or operator shall ensure that: (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential.	H 404	(b) Clinical Manager currently monitors and ensures that the Home Health Certification and Plan of Care (form 485) are updated within 48 hours of the submitted revisit paperwork. A copy of this 485 currently kept on the chart (to show that is was done) while the original is sent out the physician for his/her review and signature. (b) Revisits are routinely done every 3 months or as per the request of the vendor (on their authorizations.) The time frame indicated on this form 485 coincides with the authorization time frame. There are instances when a revisit is scheduled for a date that is past the time frame on this form 485. That is due to the fact that the previous visit was done in the middle of the time frame of the previous form 485. Many authorizations are coming in with a time period of longer than a 3-month time span.	Ongoing
	This Rule is not met as evidenced by: Based on record review and interview, the agency failed to ensure that all plan of cares were available for review. This was evident in (3) out of (6) patient records reviewed. (Patient #4, #5 and #6). Failure to ensure that Plan of Cares are available for review places the patient at risk for not receiving all the services that patient is entitled to receive. The findings are: 1) Patient #4 has diagnoses which includes Hypertension and Osteoarthritis. The agency : "Home Health Certification and Plan of Care" documents the last certification period as "4/3/07-7/31/07." There is no documented evidence of a Plan of Care for 8/1/07 until present (12/2007). 2) Patient #5 has diagnoses which includes		(See H404 Paragraph # 2) Clinical Manager currently monitors and ensures that the patient charts are being reviewed by their case managers and the copy of the form 485 (Home Health Certification and Plan of Care) is currently kept on the chart until the signed original one is returned. This procedure currently in effect. All plan of cares will be available for review during surveys. (See H404 Paragraph # 3) Clinical Manager currently monitors and ensures that the nurses complete a health care plan with the physician's approval. The Nursing Department currently includes the specific types of services required, the method of providing those services, and the expected duration of the services. (See H404 Paragraph # 3) Clinical Manager is responsible for assuring that the medical records in the health care plan include whenever appropriate the following: • Diagnosis & prognosis • Transfer forms • Physician's certification and orders • Progress notes • Drug administration records • Treatment records • Emergency instructions	Currently Ongoing

New York State Department of Health

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 5	H 404	(See H404 Paragraph # 4) 1) Department Clinical Manager / Case managers is effectively conducting weekly ground round meetings including chart and medication reviews with staff for updates and processes for improvements. When applicable the Clinical Manager determines activities, which constitutes a high-risk process, and conducts a Performance improvement activity, including data collection, analysis, aggregation and improvement measurements. This systemic approach will ensure that the deficient practice does not recur.	Weekly
			(See H404 Paragraph # 5) As part of our newly implemented practice, we are placing copies of Plan of Care (form 485) on the chart while we are waiting for the original signed ones to be returned form the doctor. This is just a confirmation that one has been done for the appropriate time period.	Ongoing
			(See H404 Paragraph # 6) During this time frame the Nurse Case Manager for Guildnet was called repeatedly requesting a new authorization. Americare, Inc. does not send in a nurse to a patient's home without an authorization. There is Documentation in the chart showing the time we called Guildnet.	Ongoing

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 5 Hypertension, Diabetes and Arthritis. The agency: "Home Health Certification and Plan of Care" documents Plans of Care for "2/1/06 - 5/1/06, 8/1/06-11/1/06, 11/2/06-2/1/07, 4/1/07-7/31/07 and 7/24/07-11/30/07." There was no documented evidence of a Plan of Care for 5/2/06-7/31/06 and 2/2/07 - 3/31/07. 3) Patient#6 has a diagnoses which includes Gout, Arthritis and Hypertension. The agency: "Home Health Certification and Plan of Care" documents Plans of Care for 12/1/06-4/1/07 and 9/1/07 - 11/30/07. There was no documented evidence of a Plan of Care from 4/1/07-8/31/07 and 12/1/07 till current. On 12/5/07, the Administrator was interviewed and was unable to provide an explanation.	H 404	(See H404 Paragraph # 8) Clinical Manager assures that all copies of the Plan of Care (form 485) are kept in the chart until the Nursing Department receives the original signed ones from the doctor. (See H404 Paragraph # 9) Department Clinical Manager / Case Managers is effectively conducting weekly ground round meetings including chart and medication reviews with staff for updates and processes for improvements. When applicable the Clinical Manager determines activities, which constitutes a high-risk process, and conducts a Performance improvement activity, including data collection, analysis, aggregation and improvement measurements. (Ans. for H404 paragraph 10 See H404 Paragraph # 9) Same as above (Ans. for H404 paragraph 11 See H404 Paragraph # 9) Same as above	Weekly
H 616	766.5(b)(2) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (2) staff are assigned to the care of patients in accordance with their licensure, and their training, orientation, and demonstrated skills. This Rule is not met as evidenced by: Based on record review and interview the agency failed to ensure that new Home Health Aides	H 616	(See H404 Paragraph # 12) The Administrator is overseeing that the Clinical Manager assures that all copies of the Plan of Care (form 485) are kept in the chart until the Nursing Department receives the original signed ones from the doctor. (Ans. for H 616 paragraph1See H616 Paragraph # 2 & 3) (See H616 Paragraph #2) (b) The Clinical Manager evaluates all field nurses annually. The evidence of adequate supervision place in the employee's HR file.	Immediately implemented Annually

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 6	H 616	(See H616 Paragraph #3) (2) The Clinical Manager assigns the internal and external staff according with their licensure, and their training, orientation, and demonstration. (2) Routine nursing training meetings are held individually with clinical manager as a follow-up measure to ensure that deficient practices do not recur. Updated information , policies, and procedures are distributed to staff. (2) Meetings were held by clinical manager with each nurse individually on theses dates, 11/06/07,11/27/07,12/11/0712/28/07,1/25/08,2/28/08 . (See H616 Paragraph # 4) Response from DOH can take up to a year to receive determinations. A new procedure to indicate that the fingerprints were definitely sent and received by the DOH is commenced immediately. When prints are forwarded we receive a confirmation from the DOH. A copy of this confirmation is now placed into the HHA file as a matter of record. Plans for improvement entails the following which is currently in practice: The first on-site supervision is completed by a nurse (RN or LPN) Subsequent on-site supervision and the off-site supervision is completed by utilizing an individual employed by the covered provider with a minimum of one year's experience. Director of Quality Assurance implemented a CHRC process in 09/07 . The Director of Quality Assurance hired 7 Home Health Aides in September and October with a one-year tenure with Americare inc. to work as CHRC Representatives for phone call and off-site supervisions. • 3 English Speaking Representatives • 1 Spanish Speaking Representative • 1 Chinese Speaking Representative • 2 Russian Speaking Representatives	Monthly Bi-weekly

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 6	H 616	(Continuation of H616 Paragraph # 4) The Quality Management Department created a new CHRC tracking database as well as new CHRC forms in order to further assist with the newly revised CHRC process. • The CHRC Nursing Supervision Visit form • The CHRC Staff Supervision Visit form • The Provisional Supervision Time- slip All staff that provides supervision of home health aides was in-serviced on the rules for supervisory visits and the agencies policy for supervision by the Director of Quality Assurance. Although we were deficient with the supervisory visits. Future supervisory visits will be in compliance from 2/19/08. Supervisory visits have been added to the agencies QA and will be audited for compliance to the rules. The Administrator will take appropriate action if noncompliance is still found. The Director of Quality Assurance and Administrator is responsible for this plan of correction.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 6 were supervised according to the Criminal History Check requirements. This was evident for (4) out of (6) employee records reviewed. (Employees # 1, #2, #3 and #4). Failure to provide supervision during a Criminal History check, places the patient at risk for unsafe care. The findings are: 1) Employee # 1 is a Home Health Aide with a documented hire date of "10/1/07." The Criminal History background check is documented as sent on " 9/30/07". The clearance letter from the Department of Health is dated 10/29/07. The personnel record does not include documented evidence of supervision during this time. 2) Employee #2 is a Home Health Aide with a documented hire date of "6/25/07." The Criminal History background check form is documented as sent on "6/21/07." The clearance letter from the Department of Health is dated "8/9/07." The personnel record does not include documented evidence of supervision during this time and Employee #2 was working a 24 hour case. 3) Employee #3 is a Home Health Aide with a documented hire date of "7/13/07."	H 616	(See H616 Paragraph # 5) The Quality Management Department is working closely with the HR and Nursing Departments to pull together the information needed to make decisions and comply with the Criminal History check regulations and policies and procedures. In addition, performance is being tracked using predefined indicators and thresholds. All staff that provides supervision of home health aides was in-serviced on the rules for supervisory visits and the agencies policy for supervision by the Director of Quality Assurance. Although we were deficient with the supervisory visits. Future supervisory visits will be in compliance from 2/19/08. Supervisory visits have been added to the agencies QA and will be audited for compliance to the rules. The Administrator will take appropriate action if noncompliance is still found. The Director of Quality Assurance and Administrator is responsible for this plan of correction. (See H616 Paragraph # 6) 1) The employee first day of work is 10/1/07 and the hire date is 9/30/07. Human Resources department is in the process of auditing all files from 2006 until 2007. (See H616 Paragraph # 7) Human Resources Department/Personnel Records department is making sure all files have the correct hire date, and no longer use the first day of work as the hire date on paperwork. (See H616 Paragraph # 8) HR Manager was hired on 12/07 to oversee the Fingerprinting Department. She has identified the problem and adheres to all regulations. Furthermore, she hired a CHRC Authorized Person and Supervisor 1/08 in order to track, trend, monitor , follow-up all fingerprinting correspondence from the DOH.	Continuous Currently Currently Ongoing

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 7	H 616	(See H616 Paragraph # 9) All staff that provides supervision of home health aides was in-serviced on the rules for supervisory visits and the agencies policy for supervision by the Director of Quality Assurance. Although we were deficient with the supervisory visits. Future supervisory visits will be in compliance from 2/19/08. Supervisory visits have been added to the agencies QA and will be audited for compliance to the rules. The Administrator will take appropriate action if noncompliance is still found. The Director of Quality Assurance and Administrator is responsible for this plan of correction.	2/19/08
			(See H616 Paragraph # 10) 2) The employee first day of work is 6/25/2007 and hire date is 6/21/2007.	
			(See H616 Paragraph # 11) Human Resources Department/Personnel Records department is making sure all files have the correct hire date, and no longer use the first day of work as the hire date on paperwork.	Currently
			(See H616 Paragraph # 12) A new procedure to indicate that the fingerprints were definitely sent and received by the DOH is commenced immediately. When prints are forwarded we receive a confirmation from the DOH. A copy of this confirmation is placed into the HHA file as a matter of record.	Immediately implemented
			(See H616 Paragraph # 13) HR Compliance Supervisor, will conduct a staff personnel record review on a quarterly basis to ensure each personnel record contains the documentation of clinical supervision as required by 02/19/08. The prompt for the quarterly review of the staff personnel records by the HR director will be the electronic desk planner of all scheduled facility meetings and activities that is posted on the agency's local area network is responsible for this plan of correction.	Quarterly

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 7	H 616	(See H616 Paragraph # 14) Human Resources Department/Personnel Records department is making sure all files have the correct hire date, and no longer use the first day of work as the hire date on paperwork.	

New York State Department of Health

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 616	Continued From Page 7 The Criminal History background check form is documented as sent on "7/13/07" and the clearance letter from the Department of health is dated "8/29/07." The personnel record does not include documented evidence of supervision during this time. 4) Employee #4 is a Home Health Aide with a documented hire date of "10/18/06." There was no documented evidence of when the background check was sent. The clearance letter from the Department of Health is dated "8/13/07." The employee has a documented start date as "12/06" The personnel record did not include documented evidence of supervision from 12/06 until 2/8/07. There is no documented supervision for the month of May and June, 2007 and the week of 7/ 25/07 and 8/ 1/ 07. On 12/5/07 at 4:30 PM the Administrator was interviewed and was unable to provide an explanation.	H 616	(See H616 Paragraph # 15) A new procedure to indicate that the fingerprints were definitely sent and received by the DOH is commenced immediately. When prints are forwarded we receive a confirmation from the DOH. A copy of this confirmation is being placed into the HHA file as a matter of record. (See H616 Paragraph # 16) HR Compliance Supervisor, will conduct a staff personnel record review on a quarterly basis to ensure each personnel record contains the documentation of clinical supervision as required by 02/19/08. The prompt for the quarterly review of the staff personnel records by the HR director will be the electronic desk planner of all scheduled facility meetings and activities that is posted on the agency's local area network is responsible for this plan of correction. (See H616 Paragraph # 18) HR Manager was hired on 12/07 to oversee the Fingerprinting Department. (See H616 Paragraph # 18) Two new employees have been hired on 12/24/07 to oversee the fingerprinting process. After CHRC coordinator has completed fingerprints, Compliance Supervisor currently reviews all files before given to Personnel Record Department. The Personnel Record Supervisor is responsible for auditing the file before it is filed away. This ensures all files be completed with evidence that the background check was sent. (See H616 Paragraph # 18) The HR Manager will monitor the effectiveness of corrective action on a timely basis until problem resolution occurs. Results of the implemented corrective action have been documented and communicated to the Direct of HR and the Administrator.	Immediately implemented Quarterly Ongoing
H1020	766.9(j) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (j) ensure the development and implementation of a patient complaint procedure to include:	H1020		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 8	H1020	(See H616 Paragraph # 19) HR Manager is overseeing the Fingerprinting Department. She has identified the problem and adheres to compliance. She hired another CHRC Authorized Person and Supervisor 1/08 in order to track, trend, monitor, follow-up and monitor all fingerprinting correspondence from the DOH.	Currently
			(See H616 Paragraph # 20) HR Compliance Supervisor, will conduct a staff personnel record review on a quarterly basis to ensure each personnel record contains the documentation of clinical supervision as required by 02/19/08. The prompt for the quarterly review of the staff personnel records by the HR director will be the electronic desk planner of all scheduled facility meetings and activities that is posted on the agency's local area network is responsible for this plan of correction.	Quarterly
			(Continuation of H616 Paragraph # 20) All staff that provides supervision of home health aides was in-serviced on the rules for supervisory visits and the agencies policy for supervision by the Director of Quality Assurance. Although we were deficient with the supervisory visits. Future supervisory visits will be in compliance from 2/19/08. Supervisory visits have been added to the agencies QA and will be audited for compliance to the rules. The Administrator will take appropriate action if noncompliance is still found. The Director of Quality Assurance and Administrator is responsible for this plan of correction.	2/19/08
			(See H616 Paragraph # 21) The administrator has put the above process and procedures into affect and will assure continuous compliance.	

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 8 (1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received by the agency; (2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint: (i) explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and (ii) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed; (3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal; and (4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to have a complete log which documents the resolution of complaints. Failure to have a complete complaint log places the patient at risk for poor quality of care. The findings are: The agency " Complaint Log " has no	H1020	(See H1020 Paragraph #3) (1) The Quality Management Department has established a process for prompt resolution of patient complaints. Grievance Coordinator was hired on 11/20/07. A log of all complaints is currently kept by date, person, allegation, follow-up and outcome/ resolution of complaint. (See attachments) (See H1020 Paragraph #3) (1) This log is utilized for statistical evaluation, service evaluation for trends, and is available for review by the NY State Department of Health and JCAHO. (See H1020 Paragraph #4) (2) The Quality Assurance Department ensures that the staff informs patients that they have several avenues for expressing concerns and that filing a grievance is not the only mechanism to ensure that they receive a satisfactory response. (See H1020 Paragraph #4) (2) Director of Quality Assurance implemented a 2008 grievance procedure, which encourages an open communication between patients and facility staff. Patients are offered assistance in formulating and submitting grievances and timely resolution of problems by our QM staff. Most complaints may be more effectively addressed and resolved by informal means. (See H1020 Paragraph #4) (2) In order to prevent a recurrence of this deficiency .The QM staff was in serviced on patient rights and the fact that that they have the right to have their concerns heard by upper management as well. (See H1020 Paragraph #5) (i) The Grievance Coordinator then Director of Patient Services / Quality Assurance reviews each grievance / complaint and responds to the complaint explaining the agency's decisions and actions within fifteen (15) days of receipt of the grievance / complaint and informs the complainant of the right to appeal the decision to the governing authority within 15 days of receiving the decision. Written complaints receive written responses.	Continuous Continuous Immediately implemented Ongoing

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 9	H1020	(See H1020 Paragraph #6) (ii) Director of Quality Assurance assumes a proactive role in the prevention, facilitation, and resolution of complaints and grievances, including implementing educational programs that assist Americare Inc. staff in handling difficult situations. Americare Inc. is authorized to act as an expert investigator, to gather information from the complainant/grievance and/or facility by phone, letter, email, and/or to make on-site reviews and to interview other staff and patients.	Continuous
			(See H1020 Paragraph #7) 3) The Grievance Coordinator currently documents receipt of the grievance / complaint, investigation, resolution, PQIC Committee findings and appeals in the patient's clinical record, agency chronological grievance file and log. The Administrator developed an appeals review committee effective 2/08. Members include: • Administrator • Assistant Director of Operations • HR Manager • Contracting Supervisor • Grievance Coordinator • Director of Quality Assurance	Ongoing
			(See H1020 Paragraph #7) (3) All grievance / complaints are discussed at the next Performance, Quality Improvement Committee meeting for review and recommendation.	Quarterly
			(See H1020 Paragraph #8) (4) It is the goal of the Americare Inc. is to meet needs and expectations of our patients. In the event that a patient is not satisfied with the response they receive, they may contact Quality Assurance Director or Administrator. If they are not satisfied with the results of the complaint investigation and resolution they are advised to contact the Department of Heath.	Continuous

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 9	H1020	(See H1020 Paragraph #9) The Grievance Coordinator currently documents receipt of the grievance / complaint, investigation, resolution, PQIC Committee findings and appeals in the patient's clinical record, agency chronological grievance file and log. (See H1020 Paragraph # 10) The Quality Management Department has established a process for prompt resolution of patient complaints. Grievance Coordinator was hired on 11/20/07. A log of all complaints is currently kept by date, person, allegation, follow-up and outcome/ resolution of complaint. This log is utilized for statistical evaluation, service evaluation for trends, and is available for review by the NY State Department of Health and JCAHO.	Currently Continuous

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From Page 9 documented evidence of a date of resolution for the complaints. On 12/5/07 at 4:13 PM, the Director of Patient Services was interviewed and stated " It will be added today. "	H1020	(See H1020 Paragraph # 11) A resolution section was added to the complaint log on 12/05/07.	Immediately implemented
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section;	H1036	(See H1036 Paragraph #2) (l) Quality Improvement Meeting was held on Wednesday, January 30, 2008. The Director of Quality assurance served as the chairperson of the Committee on that day. (See H10360 Paragraph #2) (l) The committee consisted of at least one or more of the following professionals: a. Physician b. Registered Professional Nurse c. Representative of rehabilitative services (See H10360 Paragraph #2) (l) The committee is scheduled to meet quarterly. (See H1036 Paragraph #3) (1) Administrator and Quality Assurance Director ensures consistent, standardized practices company-wide. An updated quality manual serves this purpose and is updated annually for distribution. (See H1036 Paragraph #3) (1) Findings, questions and recommendations, were analyzed and presented by the Manager of Clinical Services, to the entire committee.	1/30/08 Continuou

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 10	H1036	(See H1036 Paragraph #4) (2) Fundamentally, compliance efforts have been designed by the Administrator, Quality Assurance Director, and Clinical Manager to establish and promote prevention, detection, and resolution of instances of conduct that do not conform to Federal and State law, program requirements. Americare Inc. ensures continuous improvement initiatives by: • Conducting Nursing and HR chart audits • Identifying the area or activities that we would like to make better • Planning what is needed to be done to bring about improvement • Making the improvements • Deciding what needs to be done and checking how well it worked. The uses of audits and /or other evaluation techniques have been used to monitor compliance and assist in the reduction of identified problem areas. (Targeted date of completion = 4/08).	Ongoing
			(See H1036 Paragraph #4) (2) The Director of Education has developed and implement regular, effective education and training programs for all affected departments and/or employees. The Director of Education trained the nursing staff on compliance, documenting, and charting on 1/25/08, 2/28/08.	1/28/08
			(See H1036 Paragraph #5) (I) Random selection of records of patients currently receiving services and patients discharged from the agency within the past three months was conducted by the Clinical Manager and was review, analyzed and presented to the Quality Improvement Committee on 1/30/08. (See H1036 Paragraph #5) (I) Clinical Manager will conduct a client record review on a quarterly basis to ensure each client treatment plan contains a review date. The prompt for the quarterly review of the client records by the Clinical Manager will be the electronic desk planner of all scheduled facility meetings and activities that is posted on the agency's local area network.	1/30/08

New York State Department of Health

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From Page 10	H1036	(See H1036 Paragraph #6) (ii) All records of patients who have filed a grievance/ complaint during the previous three months; were summarized by the Grievance Coordinator and QM liaison in including statistical reports. These reports reflected grievance/incident explanations, resolution timeframes, patient interaction, as well as patient satisfaction.	1/30/08

New York State Department of Health

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 10 (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the Quality Improvement meetings included all required topics and that a physician and a consumer were present at the meetings. Failure to have a physician and a consumer at the Quality Improvement Meetings and failure to address all required topics places the patient at risk for substandard care. The findings are: The agency " Performance Improvement Committee Meetings are documented as conducted on "1/4/07, 12/4/07, 10/5/06, and 9/21/06." There is no documented evidence of physician and consumer presence at the meeting. There was no documented evidence that complaints , a random selection of patient records or discharged records were was discussed. On 12/5/07 at 2:35 PM, the Administrator was interviewed and stated: "....those things have not occurred (discharged cases)."	H1036	(See H1036 Paragraph #7) (3) The responsibilities and reporting of Quality Improvement Committee Members entails the following: Meeting at least four times a year; • Performing Clinical Record Audits • Making recommendations to the Governing Authority regarding Agency staffing and patient related care needs, as well as community service needs	Quarterly
			(See H1036 Paragraph #7) (3) Making recommendations regarding further in-service educational needs of staff and as it relates to improved service delivery and clinical trends in care; • Conducting a clinical record review of the safety, adequacy, type and quality of services provided • Submitting a written summary of committee findings and recommendations to the governing authority for review and action	Quarterly
			(See H1036 Paragraph #8) (4) The Administrator is organizing and directing the agency's ongoing functions and maintains ongoing liaison among the governing body, the group of professional personnel, staff and with other health care providers in the community	Ongoing
			(See H1036 Paragraph # 9) A physician and a consumer were present during our Quality Improvement Committee on 1/30/08 and will be present for all meetings in order to address all required topics. (See attachments)	1/30/08
			(See H1036 Paragraph # 10) A physician and a consumer were present during our Quality Improvement Committee on 1/30/08 and will be present for all meetings in order to address all required topics.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 11	H1036	(See H1036 Paragraph # 11) Americare Inc. policies do not require a Physician and a consumer to be present during Performance Improvement Committee meeting. A physician is required to attend our Professional Advisory Committee. We have documented minutes indicating at the a board member, Administrator, Vice President, Physician, and Directors attending the following meeting on 11-14-06, 3-7-07, 7-25-07, 11-21-07. (See attachments) (See H1036 Paragraph # 11) Americare Inc. currently has a Quality Improvement Committee and is scheduled to meet quarterly. (See H1036 Paragraph # 12) A consumer and a physician are part of the committee and will be present for all meetings. (See H1036 Paragraph # 13) On 1/30/08 Clinical Manager and the Grievance Coordinator presented complaints and discussed a random selection of active and discharged patient records. (See H1036 Paragraph # 13) The Administrator, Director of Quality Assurance and Clinical Manager ensures ongoing data collection for high priorities from all of the departments this measure and process is used to monitor performance, the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement, or sustain improvement. (See H1036 Paragraph # 14) The administrator of this agency since July 23, 2007, has put the above regulations into effect.	Quarterly 1/30/08 Immediately implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 11	H1142		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly	H1142	(See H1142Paragraph #1) (o) On 12/05/07 the day of the survey, , Director of Quality Assurance was asked to logon to the HPN site and demonstrate navigation. She was able to successfully login and provide compliance. Furthermore, she is a CHRC authorized person and a DOH designee with Administrative rights. The Director assures and maintains compliance by continually updating the managing tool and directories for our Americare Inc. HPN Coordinators since 1/07. (See H1142Paragraph #1) (o) Administrator was issued an HPN account on 1/3/08 .Americare Inc. currently has a policy defining the agency's HPN coverage consistent with the agency's hours of operation and is created and reviewed by the Administrator no less than annually. (See H1142Paragraph #2) (1) Americare Inc. HPN coordinators continues to adhere to all the requirements of the HPN user contract current and complete updates of the communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and a minimum, on a monthly basis. (See H1142Paragraph #3) (2) The Director of Quality Assurance, Director of Marketing and CHRC Authorized persons at Americare Inc. has HPN accounts. Administrator was issued an HPN account on 1/3/08. (See H1142Paragraph #3) (2) The Administrator ensures rapid response to request for information by the State and/or local Department of Health.	12/05/07 Monthly 1/3/08 Ongoing

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 12	H1142	(See H1142Paragraph #4) (3) Americare Inc. HPN coordinators continues to adhere to the requirements of the HPN user contract current and complete updates of the communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and a minimum, on a monthly basis.	Continuous
			(See H1142Paragraph #5) (4) The Director of Quality Assurance assures and maintains compliance by continually updating the managing tool and directories for our Americare Inc. HPN Coordinators since 1/07. (4) Administrator was issued an HPN account on 1/3/08.	Continuous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 12 basis. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to have a written policy and procedure for the Health Provider Network (HPN). Failure to have written policies and procedures for HPN places patients at risk in emergency situations The findings is: There is no documented evidence of policy and procedure for Health Provider Network. On 12/5/07 at 4:15 PM the Administrator was interviewed and was unable to provide an explanation.	H1142	(See H11142 Paragraph # 6) Americare Inc. currently has a written policy and procedure for the Health Provider Network (HPN). (See enclosed attachment) (See H11142 Paragraph # 7) Americare Inc. currently has a written policy and procedure for the Health Provider Network (HPN). (See H11142 Paragraph # 8) Americare Inc. currently has a written policy and procedure for the Health Provider Network (HPN). (See H11142 Paragraph # 9) Administrator was issued an HPN account on 1/3/08. (See H1432 Paragraph #1) (a) The Administrator ensures rapid response to request for information by the State and/or local Department of Health; shall ensure the prompt submission of all records and reports required by the department.	Immediately implemented Immediately implemented Immediately implemented 1/3/08 Ongoing
H1432	766.12(a)(3) Records and reports 766.12 Records and reports. (a) The governing authority or operator shall ensure the prompt submission of all records and reports required by the department and that: (3) at a minimum, the following reports and records are retained by the home care services agency and available to the department upon request: (i) minutes of the meetings of the governing authority and the committees thereof which shall be retained for three years from the date of the meeting;	H1432	(See H1432 Paragraph #2) (3) All patient records are being maintained as per regulations.	Ongoing

STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1432	Continued From Page 13	H1432	(See H1432 Paragraph #3) (I) Quality is everyone's responsibility and it is important that both the medical and the administrative leadership assume a key role in ensuring that the quality program is effective in achieving its objectives. Leadership is assured through a variety of mechanisms, including representation on the quality committees and substantial involvement in the development and implementation of the quality program. (See H1432 Paragraph #3) (I) Minutes of PAC meetings of the governing authority and the committee thereof will be retained for three years from the date of the meeting.	Quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1432	Continued From Page 13 (ii) records of all financial transactions directly related to delivery of patient care which shall be retained three years from the date of the transaction; (iii) personnel records, which shall be retained three years from the date of employee termination or resignation; (iv) records of grievances and complaints which shall be retained for three years from the date of resolution; (v) all records related to patient care and services; and (vi) any other records required to be kept by this Part or Part 765. This Rule is not met as evidenced by: Based on record review and interview, the agency failed to maintain documentation of patient care and services. This was evident for 1 of 6 patient care records reviewed. (Patient #2). Failure to have documentation of care for a patient places the patient at risk for unsafe and substandard care and violates the patient ' s rights. The findings are: Patient #2 has diagnoses which include Transient Ischemic attack. There was no documented evidence that the patient received the Bill of Rights; was informed of financial liability and received Advanced Directives.	H1432	(See H1432 Paragraph #4) (ii) All patient records are being maintained as per regulations. (Ans. of question H1432 # 5 See H1432 Paragraph #1-4) See above (Ans. of question H1432 # 6 See H1432 Paragraph #1-4) See above (Ans. of question H1432 # 7 See H1432 Paragraph #1-4) See above (Ans. of question H1432 # 8 See H1432 Paragraph #1-4) See above (See H1432 Paragraph # 9) This patient is a private patient (Guardianship Project). An initial nursing visit was done. With this vendor, they inform us when a nursing visit should be done (based on the patient needs). (Continuation of H1432 Paragraph # 9) When our case manager, after reviewing the chart, notes that a visit has not been done for a long period of time (more than 6 months) she can then call the vendor and ask them if they would like us to reassess the patient. Only upon their request can we go in to see the patient. As was in the case of patient #2. A request was made for revisit in January 2008 and subsequently every 6 months.	Ongoing Ongoing

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1432	Continued From Page 14	H1432	(See H1432 Paragraph # 10) To enhance currently compliant operations and under the direction of the Clinical Manager, on (3/3/08 all nursing staff will receive in-service training regarding care plans, appropriateness and policies and procedures. The training will emphasize the importance of documentation of care as well as reporting problems to the Clinical Manager or Director of Patient services immediately. (Ans. of question H1432 # 11 See H1432 Paragraph #12) See above (See H1432 Paragraph # 12) The Quality Management and Nursing Departments understand the importance of documenting. The nursing staff was in-service by the Clinical Manager on how to document discussions with patients or their surrogates about critical issues, DNR, Do Not Hospitalize orders, decision about artificial nutrition and hydration for unintentional weight loss, palliative versus curative care for pressure ulcers, and other decisions to forego or limit evaluations and interventions for conditions arising at the end of life. Americare Inc. currently has policies and practices in place to address these issues. This measure was put in place to ensure that deficient practices do not recur for those patients found to have been affected by the deficient practice. (See H1432 Paragraph # 12) On patient #2's revisit, dated 01/24/2008 a Bill of Rights was given to the patient and a signed (by the patient) Patient Orientation Form was place into the chart.	3/3/08 1/24/08 – Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0423A	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	205 KINGS HIGHWAY BROOKLYN, NY 11223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1432	Continued From Page 14 There was no documentation of a Plan of Care, medical orders, aide activity sheets or supervisory reports. There was documented evidence of the RN approval of admission, a Nursing Assessment and progress notes. On 12/5/07 at 2:50 PM, the Director of Patient Services was interviewed and stated " I'm sure there are medical orders but not in the chart. It is possible the information is not there. "	H1432	(See H1432 Paragraph # 13) The Home Health Certification and Plan of Care was not produced due to the fact that the case was terminated within one week of receiving back the paperwork from the field nurse. (See H1432 Paragraph # 14) Fundamentally, compliance efforts have been designed by the Administrator, Quality Assurance Director, and Clinical Manager to establish and promote prevention, detection, and resolution of instances of conduct that do not conform to Federal and State law, program requirements. Quality Assurance and Nursing Departments is ensuring continuous improvement initiatives by: • Conducting Nursing and HR chart audits • Identifying the area or activities that we would like to make better • Planning what is needed to be done to bring about improvement • Making the improvements • Deciding what needs to be done and checking how well it worked (See H1432 Paragraph # 13) The uses of audits and /or other evaluation techniques have been used to monitor compliance and assist in the reduction of identified problem areas. (Targeted date of completion = 4/ 15/08). (See H1432 Paragraph # 13) The Director of Quality Education developed and implement regular, effective education and training programs for all affected departments and/or employees. The Director of Education trained the nursing staff on compliance, documenting, and charting on 1/25/08,2/28/08. (See H1432 Paragraph # 15) Department Clinical Manager / Case Managers is effectively conducting weekly ground round meetings including chart and medication reviews with staff for updates and processes for improvements. When applicable the Clinical Manager determines activities, which constitutes a high-risk process, and conducts a Performance improvement activity, including data collection, analysis, aggregation and improvement measurements. This measure was put in place to ensure that deficient practices do not recur.	4/15/08 12/10/07 - Ongoing

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1394L001	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full Survey was performed at All Metro Health Care on 03/12/08 and 03/13/08. Nine (9) Patient Records were reviewed and are identified as Patients #1 to #9. Two (2) Home Visits were made to Patients #4 and #6. The agency's Home Health Aide Training Program (HHATP) was reviewed and eight (8) HHATP Training Records were reviewed and are identified as Trainees #1 to #8. Eight (8) Personnel Records were reviewed and are identified as Employees #9 to #16. A total of sixteen (16) Personnel Records were reviewed that included the HHATP Trainee records #1 to #8.	H 000		
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges;	H 204	Amended 5-6-08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Cathy Kelly Rn & VP of Patient Services 5-6-08

2. The POC lacked any reporting to the Governing Authority regarding the QIC activities/review results and/or recommendations to the Governing Authority that would affect the quality of patient care services.

H1337 - 766.11 (f) (ii) Personnel:

1. The POC failed to include any ongoing review of the temporary paraprofessional records to ensure compliance and that the actual supervision was performed by the agency and filed into the personnel record.

2. The POC failed to include any reporting to the Governing Authority.

Please be advised that pages #19 to #21 were not included with the original Statement of Deficiencies.

We apologize for the error and any inconvenience that has been caused to the agency.

Enclosed are pages #1 to #21 inclusive for the agency's review.

Thank you.

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1394L001	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 1 (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient. (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Rule is not met as evidenced by: Based on review of the admission packet, home visits, patient records review, and staff interview, the agency failed to provide their patients with accurate information regarding the payor sources from which the agency could accept payment and the related charges for the services available by the agency. This was evident in three (3) of nine (9) patient records reviewed (Patients #1, #3, and #9) admitted after 12/05 when the Agreement for Service was revised and in one (1) of two (2) home visits (Patient #6). The failure of the agency to advise the patients of accepted payor sources, and related charges for the services available by the agency places the patient's at risk for financial liability for services provided by the agency.	H 204	**H204 - 766.1(a)(1) Patient Rights** AMHC's Patient Rights and Responsibilities (Exhibit A) has been amended, deleting the word "Medicare" in section 10. A copy of the amended Bill of Rights shall be mailed/delivered to all patients currently on services by 6/30/08 to clear up any misunderstanding regarding sources of reimbursement. All associates will be oriented to this change during a staff meeting. AMHC's Agreement for Service (Exhibit B) has been revised deleting the term Medicare. Moving forward, only the updated form shall be used. The responsible associate is the Director of Clinical Services (DCS) and the Sr. VP of Patient Services who is a member of the Governing Authority. Completion date 5-31-08 Accepted 6/6 8/7/08 Amended I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1394L001	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 2 Findings include: Review of the Patient Rights and Responsibilities, and Agreement for Service in the admission packet and patient records #1, #3, #6, and #9, the column #10 on the Patient Bill of Rights reads "As a patient you have the right to: Be fully informed, orally and in writing, at the time of admission, and in advance of the care provided ... must include all items and services for which you may be responsible reimbursement, eligibility for third party reimbursement, coverage available under Medicare, Medicaid, and any other federal program of which the agency is aware." Review of the Agreement for Service revised 12/05 documented under the heading Authorization of Payment that "If a Medicaid client, I authorize All Metro Health Care to apply under Title XIX/XX, or to Medicare if a Medicare patient, and authorize payment directly to All Metro Health Care. I authorize release by All Metro Health Care of all records necessary to obtain payment." During home visit to Patient's #6 home on 03/13/08 at 9:00 AM, review of Patient Rights and Responsibilities and Agreement for Service agreement included the information, that Medicare was a payor source in the admission packet. An interview was conducted on March 12, 2008 at 2:00 PM with the Acting Director of Clinical Services (ADCS), the ADCS acknowledged the survey findings and could not provide an explanation why the information about Medicare was on the Patient Rights and Responsibilities and Agreement for Service was included on the forms since the licensed home care agencies	H 204	Amended FT	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From Page 3 cannot bill Medicare. H1002 766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency: (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on review of the patient's admission information packet, patient records, personnel records and policy and procedure review, and staff interview, the Governing Authority failed to be responsible for the operation and the management of the agency. This was evident in the following deficiencies: H0204 - 766.1 (a) (1) Patient Rights H1337 - 766.11 (f) (ii) Personnel Based on review of the Home Health Aide Training Program (HHATP) records, personnel records, policy and procedure review and staff interview, the Governing Authority failed to ensure that the HHATP is in compliance with the New York State Department of Health (NYSDOH) Guide to Home Health Aide Training and Competency Evaluation revised in April	H 204 H1002	Accepted H1002 766.9(a) Governing Authority 766.1(a) Instructors have been reoriented to the new HHATP revised in April 2006. Particular attention has been given to the need for all candidates to successfully complete all testing & competency components of the program, with remediation provided for substandard scores in any given area, as outlined in the "Guide to HHA Training and Competency Evaluation" page 5. This indicates that he program "may provide additional training...and may reevaluate the aide's competency only in those areas requiring remediation." Moving forward, such remediation shall be provided and noted in the training documentation. All Clinical Supervisors have been reoriented to the SCV (Supervised Clinical Visit) form and the correct manner of completion to ultimately include 8 hours of field supervision as well as the documentation of the required care observed. The nursing and HR associates have been reinstructed that under no circumstances is a certificate of training to be issued until all components of the training have been successfully completed. It has also been restated that henceforth, the graduate is to receive the ORIGINAL certificate, with a copy being filed in the personnel record. The graduate shall also receive a copy of the Competency Evaluation. The graduate will sign a log indicating that they received the original certificate	

Cathy Kelly Sr V/P Patient Services
5/23/08

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 4 2006. The Governing Authority's failure to be responsible for the agency's HHATP places the patients at risk for the delivery of poor patient care by the home health aides who have not satisfied the training program requirements set forth by the NYSDOH. Findings include: On 03/13/08, the agency's HHATP was reviewed onsite. The review was performed on the agency's last HHATP class that was conducted on 11/01/07 to 11/16/07. Eight (8) Trainee records and Personnel records were reviewed and are identified as Trainees #1 to #8. The major issues that were identified are as follows: 1. The trainee records and the personnel records were incomplete regarding remediation, observation and re-testing for failing grades during the HHATP. This was evident in eight (8) of eight (8) records reviewed. 2. The trainee records failed to document that the all the trainees were provided the required eight (8) hours of SPT (Supervised Practical Training) in the patient care setting. The trainee records lacked documentation to verify that the Registered Nurse (RN) had observed the required skills/tasks for all trainees in the HHATP. Certificates of Completion were issued to the Trainees prior to completion of the SPT and/or	H1002	Supervision of the HHATP instructors will be completed during each scheduled training class by the DCS. Supervision of the Program Director will be completed by the VP of Patient Services. The responsible associate is the Director of Clinical Services (DCS), the HR Coordinator and the VP of Patient Services. Next training class has been scheduled from 5/21/08-6/6/08. The VP of Patient Services is a member of the Governing Authority. As a member of the Governing Authority, the VP of Patient Services communicates on a weekly basis with the other members of the Governing Authority. All record audit reports are sent to all members of the GA and the VP of Pt Services reviews with the other members of the GA the results and also reviews the quarterly PAC activities with the GA. All changes in policy and procedure are reviewed with the GA prior to being published and the GA monitors the submission of continuous quality activities on a quarterly basis to ensure that the standards of care continue to be met. Completion Date 5/31/08 Accepted 5/27/08 Amended 5/27	

PRINTED: 05/13/2008
FORM APPROVED
New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 5 Skills/Tasks Observation by the RN. 3. The trainee and the personnel records lacked documentation that the agency provided the trainees the original Certificate of Completion and a copy of the Competency Evaluation form upon completion of the HHATP. This was evident in eight (8) of eight (8) trainee and personnel records reviewed. For example: 1. The "Independent Inservices" form documented the following: Trainee # 3 had the following test scores for: Module II (60), Module VII (50), Module VIII (65) and Midterm exam (70). The Trainee's record lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Modules II, VII and VIII. The record included the copy of the Certificate of Completion dated 11/26/07. Trainee # 1 had the following test scores for: Module II (55), Unit C (62), Unit F (65) and Final exam (68). The Trainee's record lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Module II and Unit F. The record included the copy of the Certificate of Completion dated 12/14/07. Trainee # 7 had the test score of (60) for Module II . The Trainee's record lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Module II.	H1002	Amended 7/11	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 6 The record included the copy of the Certificate of Completion dated 11/26/07. Trainees #6 and #4 had the test score of (65) for Module VIII . Trainee #4 and #6 records lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Module VIII. The record included the copy of the Certificate of Completion dated 11/26/07 for Trainee #6. Trainee #4 record lacked documentation of the copy of the Certificate of Completion. The record also lacked documentation to explain why the Certificate of Completion copy was not in the HHATP file and the Personnel record. Trainee # 8 had the following test scores for: Module II (65), Modules III and IV (60), Module VIII (60), and Unit C (70). The Trainee's record lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Modules II, III, IV, VIII and Unit C. The Trainee's record lacked documentation of the required Modules # I to # XII and Units A to H tests/quizzes. The record included the copy of the Certificate of Completion dated 11/08/07. Trainee # 2 had the following test scores for: Module II (60), Unit C (55) and Unit F (70). The Trainee's record lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Module II and Units C and F.	H1002	A Wounded Knee	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 7 The record included the copy of the Certificate of Completion dated 10/29/07. Trainee #5 had the following test scores for: Module V (50) and Unit F (70). The Trainee's record lacked documentation that the agency provided any form of remediation testing, teaching and or observation for Module V and Unit F. The record included the copy of the Certificate of Completion dated 11/26/07. Review of the agency's policy and procedures for the HHATP did not include the agency's acceptable passing grades for the all tests/quizzes. During interview on 03/13/08 at 11:10AM with the Acting Director of Clinical Services (ADCS), the Director could not locate or provide the missing documentation for the HHATP records. The Director further could not provide an explanation for the agency's failure to ensure that all the Trainees fulfill and complete the HHATP requirements. 2. Review of the "Clinical PCA/Home Health Aide Training - Skills Checklist" form listed forty three (43) skills. The form was used to document the listed skills that were observed by the RN and document that the Trainee was competent in the observed skills. The "Supervised Clinical Visit Home Health Aide Trainee" form listed thirty nine (39) tasks. The form did not include the required tasks of "TPR" (temperature, pulse and respiration), meal	H1002	Amended & H	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 8 preparation, measure intake/output and the taking of the patient's Blood Pressure. The form in the upper right hand corner documented numbers from #1 to #16. The form failed to explain the meaning of the listed numbers. The form lacked documentation of how many hours of SPT in the patient care setting was provided by the agency. The Trainee records #1 to #8 lacked documentation that the agency provided the required eight (8) hours of SPT in the patient care setting. This form was used by the agency for the SPT in the patient care setting. Trainee #1 record lacked documentation that the required SPT in the patient care setting was provided by the agency. The record also lacked documentation that the RN had observed the required skills for the SPT. The Trainee and the personnel records lacked documentation of the "Supervised Clinical Visit Home Health Aide Trainee" form used to document that the SPT was performed by the RN. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only ten (10) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down the page. Only two (2) skills were initialed by the nurse and the remaining were documented with an arrow running down the page.	H1002	Amended KTT	

PRINTED: 05/13/2008
FORM APPROVED
New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 9 The Certificate of Completion was dated 12/14/07. Trainee #2 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "11/26/07". The form documented that the RN had observed the Trainee for eight (8) of the thirty nine (39) listed tasks. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only seven (7) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down the page. Only two (2) skills were initialed by the nurse and the remaining were documented with an arrow running down the page. The Certificate of Completion was dated 11/26/07. Trainee #3 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "11/26/07". The form documented that the RN had observed the Trainee for seven (7) of the thirty nine (39) tasks only. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only seven (7) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down the page. Only two (2) skills were initialed by the nurse and the remaining were documented with	H1002	Amended x 10	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	60 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 10 an arrow running down the page. The Certificate of Completion was dated 10/26/07. Trainee #4 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "12/14/07". The form documented that the RN had observed the Trainee for ten (10) of the thirty nine (39) tasks only. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only seven (7) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down the page. Only two (2) skills were initialed by the nurse and the remaining were documented with an arrow running down the page. The HHATP record lacked documentation of the copy for the Certificate of Completion. Trainee #5 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "11/26/07". The form documented that the RN had observed the Trainee for eight (8) of the thirty nine (39) tasks only. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only seven (7) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down the page. Only two (2) skills were initialed by the	H1002	Amended 5/10	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 11 nurse and the remaining were documented with an arrow running down the page. The Certificate of Completion was dated 10/26/07. Trainee #6 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "11/26/07". The form documented that the RN had observed the Trainee for nine (9) of the thirty nine (39) tasks only. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only eight (8) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down the page. Only two (2) skills were initialed by the nurse and the remaining were documented with an arrow running down the page. The Certificate of Completion was dated 10/26/07. Trainee #7 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "11/26/07". The form documented that the RN had observed the Trainee for nine (9)of the thirty nine (39) tasks. The "Clinical PCA/Home Health Aide Training - Skills Checklist" form dated 11/08/07 documented by the RN, that only seven (7) of the forty three (43) skills were documented that competent demonstration of the skills was performed by the Trainee. The remaining skills were documented with an arrow running down	H1002		

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 12 the page. Only two (2) skills were initialed by the nurse and the remaining were documented with an arrow running down the page. The Certificate of Completion was dated 10/26/07. Trainee #8 record documented the "Supervised Clinical Visit Home Health Aide Trainee" form dated "12/14/07". The form documented that the RN had observed the Trainee for eight (8) of the thirty nine (39) tasks. The HHATP record lacked documentation of the "Clinical PCA/Home Health Aide Training - Skills Checklist" form. The record also lacked documentation to verify that the required skills were observed by the RN. The Certificate of Completion was dated 11/08/07. During interview on 03/13/08 at 11:10AM with the ADCS, the agency's staff was provided the opportunity to provide/locate any additional documentation. The Director stated that the HHATP instructor must have the other tests and training forms in her file. 3. Trainee and Personnel records #1 to #8 lacked documentation that the agency had provided the original Certificate of Completion and a copy of the Competency Evaluation forms to each Trainee upon completion of the HHATP. Trainee record #4 and the Personnel record lacked documentation of the copy of the Certificate of Completion.	H1002	Amended + II	

PRINTED: 06/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 13 The Trainee and Personnel records #1, #2, #3, #5, #6, #7 and #8 included a copy of the Certificate of Completion. The records lacked documentation that the Certificates were issued to the Trainees that completed the HHATP. During interview on 03/13/08 at 11:10AM with the ADCS, the Director could not verify that the agency had provided the original Certificate of Completion and a copy of the Competency Evaluation forms to all the Trainees that completed the HHATP	H1002		
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients	H1036	Accepted Amended 6/11	

PRINTED: 05/13/2008
FORM APPROVED
New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From Page 15 agency's services and patients discharged within the last three (3) months. The QIC meeting minutes further lacked review of the patient records regarding the safety, adequacy, type and quality of home care services provided by the agency. During interview on 03/12/08 at 1PM with the Acting Director of Clinical Services, the Director acknowledged the survey findings.	H1036		
H1337	766.11(f)(ii) Personnel Section 766.11 Personnel The governing authority or operator shall ensure for all health care personnel: (f)(ii) a criminal history record check to the extent required by section 400.23 of this Title This Rule is not met as evidenced by: Based on personnel record review, Home Health Aide Training Program review, policy and procedure review and staff interview, the agency failed to ensure that the temporary paraprofessional staff were supervised as required while awaiting the Criminal History Record Check (CHRC) results in one (1) of one (1) temporary paraprofessional staff (Employee #10), requiring CHRC and in eight (8) of eight (8) Trainee records reviewed (Trainees #1 to #8). The agency's failure to provide the required supervision of the temporary paraprofessional staff, that required the direct onsite observation	H1337	**H1337 – 766.11 (f)(ii) – Personnel** The entire branch staff has been reoriented to the process for supervision of provisional employees, and the individual responsible for scheduling the nursing visits has been replaced. She has also developed a tracking log for both the visits and the telephonic supervisions, which she completes. The associates responsible are the DCS, Branch Manager and Clinical Coordinator, who shall review the logs (See attached) weekly for compliance with the CHRC requirements. The DCS will review all of all provisional employee files to ensure that the actual supervision was performed and filed in the personnel record. This will be documented on the log which will be sent to the VP of Patient Services for review. The logs will also be reviewed during quarterly quality audits. The VP of Patient Services will review the logs and report to the GA on a quarterly basis the adherence to this process. This reporting will be done via verbal communication and written audit reports. Completion date – 5/31/08 and ongoing	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From Page 16 by the nurse for the first week and alternate weekly supervision by direct observation and telephonic supervision, places the patients at risk for poor quality care. Findings include: Review of the policy and procedure titled "NYS CHRC Policy" documented "Direct on-site observation is required for the first week the provisional employee or temp staff is used. After the first week, AMHC (All Metro Health Care), may alternate weekly, direct on-site observation with off-site, telephonic evaluation until CHRC determination is received. Off-site evaluation is conducted via a phone call to the care recipient. The on-site supervision must be completed by a nurse (RN or LPN) and the off-site by either a licensed health care professional or coordinator. The results of the observations must be documented in the temporary employee's personnel file and signed by the person providing the supervision." Employee #10 was hired on 11/12/07 and placed on her first case on 11/17/07. The initial supervision was conducted via telephone call on 12/01/07 two (2) weeks later instead of the required initial supervision being conducted onsite by the Registered Nurse (RN) while awaiting the CHRC results. During an interview with the Area Director of Clinical Services (ADCS) on 03/13/08 at 12:30 PM, the ADCS acknowledged that the agency was having a problem with conducting provisional supervision as required. Trainee #1 was hired by the agency on 12/12/07. The personnel record documented that the	H1337	Amended 4/11	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From Page 17 agency provided onsite supervision by the RN on 01/02 and 01/29/08. The offsite telephone supervision was performed on 01/18/08. The personnel record lacked documentation of any subsequent supervision by the agency of the temporary paraprofessional staff from 01/03 to 01/17/08 and 01/30/08 to 03/13/08. The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #2 was hired by the agency on 10/29/07. The personnel record documented that the agency performed offsite telephone supervision on 11/28 and 12/04/07, 01/08,1/20 and 02/07/08. The personnel record lacked documentation that the RN had performed any onsite supervision of the temporary paraprofessional staff from 11/28/07 to 02/07/08. The personnel record lacked documentation of any subsequent supervision by the agency of the temporary paraprofessional staff from 10/29/07 to 11/27/07 and 02/08/08 to 03/13/08. The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #3 record lacked documentation when the agency hired the temporary home health aide. The record documented that CHRC application	H1337	Amended	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From Page 18 form was signed and dated by the aide on 11/26/07 for submission for the CHRC review. The personnel record lacked documentation that the agency provided/performed the required onsite and offsite supervision of the temporary paraprofessional staff from 11/26/07 to 03/13/08. The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #4 was hired by the agency on 12/03/07. The record documented that CHRC application form was signed and dated by the aide on 11/30/07 for submission for the CHRC review. The personnel record lacked documentation that the agency provided/performed the required onsite and offsite supervision of the temporary paraprofessional staff from 12/03/07 to 03/13/08. The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #5 was hired by the agency on 11/26/07. The personnel record documented that the agency provided onsite supervision by the RN on 12/03/07, 01/04, 01/18 and 02/05/08. The offsite telephone supervision was performed on 12/24/07, 01/25 and 02/13/08. The personnel record lacked documentation of any subsequent supervision by the agency of the temporary paraprofessional staff from 12/04/07	H1337		

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From Page 19 to 12/23/07, 01/05 to 01/17/08 and 02/14/08 to 03/13/08. The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #6 was hired by the agency on 11/26/07. The personnel record documented that the agency provided onsite supervision by the RN on 11/30/07, 01/17, 01/24 and 02/16/08. The offsite telephone supervision was performed on 12/21/07, 01/14, 01/15, 01/25 and 02/08/08. The personnel record lacked documentation of any subsequent supervision by the agency of the temporary paraprofessional staff from 12/01 to 12/20/07, 01/26 to 02/07/08 and 02/17/08 to 03/13/08. The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #7 was hired by the agency on 11/26/07. The offsite telephone supervision was performed on 12/18/07 and 01/03/08. The personnel record lacked documentation that the RN had performed any onsite supervision of the temporary paraprofessional staff from 11/26/07 to 01/03/08. The personnel record lacked documentation of any subsequent supervision by the agency of the temporary paraprofessional staff from 12/19/07 to 01/02/08 and 01/04/08 to 03/13/08.	H1337	Amended 5/11	

PRINTED: 05/13/2008
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LCO989A	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO	50 BROADWAY LYNBROOK, NY 11563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From Page 20 The personnel record lacked documentation to explain why the agency did not provide/perform the required supervision. Trainee #8 was hired by the agency on 11/15/07. The personnel record documented that the agency provided onsite supervision by the RN on 01/10 and 03/05/08. The offsite telephone supervision was performed on 02/10/08. The personnel record lacked documentation of any subsequent supervision by the agency of the temporary paraprofessional staff from 11/15/07 to 01/09/08; 02/11/08 to 03/04/08 and 03/06/08 to 03/13/08. During interview on 03/13/08 at 10:15AM with the ADCS, the survey findings for Trainees #1 to #8 were reviewed with the agency's staff. The agency's staff was provided the opportunity to provide/locate any additional documentation. The agency's staff did not provide any additional documentation during the survey. The Director stated that the CHRC report results have not yet been received by the agency. The Director could not provide an explanation for the agency's failure to provide the required supervision of the temporary paraprofessional staff while awaiting the CHRC report results and in accordance with the agency's policy and procedure.	H1337	Amended 6/11	

U.S. Postal Service
CERTIFIED MAIL RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

7099 3400 0007 1708 8155

Article Sent To: DAVID MIDDLETON - COO

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Name (Please Print Clearly) (to be completed by mailer): ALL Metro Home Care
Street, Apt. No.; or PO Box No.: 50 Broadway
City, State, ZIP+4: Lynbrook, NY 11563

PS Form 3800, July 1999 — See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
DAVID MIDDLETON
Chief Operating Officer
ALL Metro Home Care
50 BROADWAY
LYNBROOK, NY 11563

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery MAY 14 2008

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7099 3400 0007 1708 8155

PS Form 3811, February 2004 — Domestic Return Receipt — 102595-02-M-1540

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES. INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Full Survey was conducted at Selfhelp Community Services, Inc on May 21 and May 22, 2008. Seven (7) Patient Record were reviewed and identified as patients #1 - #7. Eight (8) Personnel Records were reviewed and identified as employees #1 - # 8. Two (2) Home Visits were conducted and identified as patients #3 and #5. Five (5) Trainee Records were reviewed from the agency's Home Health Aide Training Program and identified as Trainees #1 - #5.	H 000		
H 404	766.3(b) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This Rule is not met as evidenced by: Based on patient record review and staff interview, the agency failed to develop a Plan of Care which was complete and included medications, frequency of services, and the patient's rehabilitation potential in seven (7) of seven (7) records reviewed. (Patients #1, #2, #3, #4, #5, #6, and #7).	H 404	Plan of Care: I. Clients # 1-7: An interim order will be sent to each primary M.D. and the renewal of the Plan of Care will incorporate specific client medications ,specific services,frequency of services and rehabiltitative potential. II.During the start of care ,assessments of new clients re-assessment of current clients, the nurse will address the rehabiltitive potential and identify goals that are realistic and correlate with the plan of treatment. The identified medications,frequency of services ,specific services and rehabilitative potential will be reflected on all 'Plan of Care"to be reviewed and signed by client's physician.	6/30/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES. INC.	50 CLINTON STREET HEMPSTEAD, NY ,11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 1 The agency's failure to ensure that the patient's Plan of Care is complete places all patients at risk for poor quality care. Findings are: Review of the Plans of Care for patients #1, #2, #3, #5, #6 and #7 lacked documentation that the agency developed a Plan of Care for each patient which included the patient's rehabilitation potential. Patient #7 was admitted to the agency on 01/18/08 with diagnoses of Hypertension, Early Dementia, and Depression. Review of the Plan of Care dated 01/11 - 06/11/08 lacked the amount and frequency for the following medications: Nitroglycerine, Aricept and Amoxicillin. The Plan of Care also included medication Coumadin 5mg and Coumadin 1 mg, yet the plan of care lacked which days the patient was to receive 5 mg and which days 1mg tablet. Further review of the record documented that the patient was also on Actonel 35 mg 1 pill once a week before breakfast, which was not included on the Plan of Care. Review of the record documented that the nurse was visiting the patient once a week to pre-pour the medications. Review of Skilled Nurse (SN) visit note dated 03/07/08 documented that the Coumadin dosage was on Mondays and Thursdays 5mg and Sunday, Tuesdays, Wednesday, Friday and Saturday the patient was to receive 6mg of Coumadin. The record lacked documentation that the nurse obtained an interim order for the change in Coumadin dosage. On 05/22/08 at 11:30 AM, the Clinical Director	H 404	III . The Clinical Manager will conduct In –Services for all nursing staff by June 30th on appropriately assessing/documenting client's potential for rehabilitation, medications and frequency of services and identifying realistic goals that correlate with 'Plan of Care'. IV . A focused audit will be conducted every 60 days to determine the level of compliance of 100% of client files by the Clinical Manager.The utilizationof a rehabiltation potential will be included on the medical record tool and will reviewed at the quarterly Professional Advisory Committee meeting. 404- Accepted 6/13/08 Patient # 7: ✓ I) An Interim order, which will carry over to the Plan of Care renewal time frame,was sent to the primary MD incorporating dosage and frequency for Nitroglycerine, Aricept and Actonel on 6/4/08. An Interim order effective 3/7 to 4/17/08 sent to Primary MD to reflect change in Coumadin dosage. II) During SOC assessment of new clients and re-assessment of current clients the Clinical Manager will identify and reflect all clients' medications on the Plan of Treatment to be reviewed and signed by the client's physician. To be completed by 6/30/08. Accepted 6/13/08	6/30/08 6/30/08

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 2 was informed of the survey findings. Later, the Clinical Director presented an interim order dated 04/17/08 which included change in Coumadin dosage to 5 mg by mouth every Mondays, Wednesdays and Fridays and 6 mg on Tuesdays, Thursdays, Saturdays and Sundays, this interim order was already reviewed by the surveyor during clinical record review. The Clinical Director could not provide an explanation for which days the nurse was pre-pouring 5mg and 1mg of Coumadin. Patient #4 was admitted to the agency on 01/23/08 including diagnosis of Hypertension. The Plan of Care dated 02/11 - 07/11/08 ordered home health aide service. The Plan of Care documented "Private HHA (home health aide)PRN (as needed)". The orders lacked frequency and what tasks the aide was to be assisting the patient with. Review of the aide duty sheets documented that the patient received aide services on the following days: 03/06, 03/20 and 04/29/08 to accompany patient to the physician's office. On 05/21/08 at 1:30 PM, the DPS and Assistant Vice President were informed of the survey findings and were given an opportunity to provide an explanation. On 05/22/08, the DPS acknowledged the survey findings.	H 404	Patient #7 Continued from Page 2 III) The Clinical Manager will review all RN visit reports on a weekly basis to ensure documentation standards are maintained. Commenced 6/2/08. IV)A focused audit of 100% of client records will be conducted by the Clinical Manager within 30 days with follow-up every 60 days by the Clinical Manager and DPS to determine level of compliance. Accepted 6/13/08 Plan of Care Patient #4 ; I. An interim order has been sent to M.D addressing Home Health Aide services to accompany client to M.D.visits only. Maximum frequency nine hours with the duration of every two weeks for client private hours. Notation : This client primarily is an EISEP and the Care Plan ,Plan of Care A.D.L. tasks are reflected on this contracted client. II. During the start of care an assessment of new clients the nurse will address the Home Health Aide tasks,frequency and and duration of services provided. III. The Clinical Manager will conduct In-Services for all nursing staff by June 30th on appropriately assessing /documentation the Home Health Aide tasks ,frequency and duration of services rendered by the Plan of Care. IV. Focused audit will be conductedby Clinical Manager every 60 days to determine compliance of the Plan of Care. Accepted 6/13/08	6/30/08
H 618	766.5(b)(3) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall	H 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From Page 3 consider the following factors as evidence of adequate supervision: (3) clinical records are kept complete and changes in patient condition, adverse reactions, and problems with informal supports or home environment are charted promptly and reported to supervisory staff. This Rule is not met as evidenced by: Based on patient record review, home visits (HV) and staff interview, the agency failed to ensure adequate supervision of nursing staff and the agency failed to ensure that the patient records were kept complete in three (3) out of three (3) patient records reviewed. (Patients #5, #6 and # 7). The agency's failure to ensure that the nursing staff is adequately supervised in the administration and documentation of medications places all the patients at risk for poor patient outcome. Findings include: Patient #5 was admitted to the agency on 12/05/07 with diagnoses of Bladder Polyps, Cancer of Bladder and Hypertension. The Plan of Care dated 12/05/07- 06/05/08 ordered a Foley catheter. The Aide's Plan of Care dated 12/05/07 listed tasks for the aide to assist patient with Foley care and to empty the Foley bag. A home visit was conducted on 05/21/08 at 2:50 PM accompanied by the agency's Director of Patient Services (DPS). During the home visit, the patient and spouse were interviewed and reported that the patient	H 618	H618 Clinical Records (Supervision of Nursing staff) I. Nursing staff have been evaluated and assessed in the field. II. Annually in June nursing staff will have their annual clinical field evaluations. III. In order to ensure that clinical evaluations are accomplished in June the utilization of the same time sequence as the organization's employee appraisal performance time frame. IV. The new guideline for clinical field evaluations will be in place for the calendar month of June. POC - Accepted 6/13/08 (R) Patient #5 - See Page 5 - Accepted 6/13/08 (Reviewed 6/12/08 R) (R)	6/5/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From Page 4 had a Foley catheter from the start of care 12/05/07 until the patient had surgery in February 2008. During the months of December 2007 through May 2008, the agency's nurse and home health aide provided home care services. The record lacked documentation that the patient had a Foley catheter during the months of December 2007, January 2008 and February 2008. Review of the nursing visit notes dated 01/12/08 and 02/08/08, the nurse failed to document if the patient had a Foley catheter and the nurse failed to document the supervision of the aide in performing tasks related to the Foley catheter. Further review of the patient record, the nurse failed to revise the Plan of Care after February 2008 to refect changes with the patient's Foley status. The record lacked documentation that the patient's physician was notified of these changes. Review of the aides service reports for dates of service of 12/05/07 - 02/29/08, the aide failed to document specific tasks performed to assist the patient with Foley catheter care. On 05/21/08 at 1:30 PM, the DPS and Assistant Vice President were informed of the survey findings and were given an opportunity to provide an explanation. On 05/22/08, the Administrative staff acknowledged the survey findings. Patient #6 was admitted to the agency on 12/10/07 with diagnoses of Macular Degeneration and Hypertension. The Plan of Care (POC) dated 12/10/07 ordered the Registered Nurse (RN) Q weekly (every week) to pre pour medications and do	H 618	I) Care Plan for Patient #5 was revised on 6/4/08 to reflect d/c of Foley catheter. Plan of Treatment was updated and sent to Primary MD on 6/10/08. RN counseled on 6/4/08 re: documentation standards. The Home Health Aide was counseled by the DPS on 5/31/08 re: following the patient's plan of care and reflecting tasks performed consistently on the duty sheet. II) The Clinical Manager will be responsible for conducting a focused audit of 100% of active clinical records for similar deficiencies to ensure all records meet regulatory standards. III)By 6/30/08 all RNs will receive in-service conducted by the Clinical Manager regarding standards for maintaining patient records according to guidelines including plan of care, progress notes and notification of physician for significant changes to the POC. IV) Audit findings will be reported quarterly at the PAC meetings. Accepted 6/13/08 Patient #6 - See page 6.	6/30/08

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES. INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From Page 5 medication teaching. The POC listed seven (7) medications for pre pour which includes: ASA (Aspirin), Prilosec, HCTZ (Hydrochlorothiazide), Verapamil, Zocor, Zoloft, and Oscal. Review of the nursing visit reports lacked documentation of the name, dosage, route and frequency of medications pre poured. For example, nursing visits of 12/17/08, 12/27/08, 01/07/08, 01/14/08, 01/24/08, 01/31/08, 02/07/08, 02/14/08, 02/20/08, 02/28/08, 03/06/08, 03/12/08, 03/20/08, 03/26/08,and 04/04/08 the nurse consistently documented "pre pour meds". The visit notes lacked documentation of the name, dosage, route and frequency of the medications pre poured on these dates. On 01/14/08, the nurse documented "ordered refill on Zoloft, Omeprazole, HCTZ (Hydrochlorothiazide), Zocor. Need MD to fax new script for Verapamil with correct dosage". The record lacked documentation of the names of medications pre-poured on this date and the follow-up revisit date for the nurse to pre pour the remaining medications. Further review of the nursing visit reports, on the visit dates of 04/09/08, 04/18/08, 04/25/08, 05/02/08, 05/07/08, and 05/15/08 the nurse documented that six (6) medications were pre poured. The nurse failed to document the pre pour of the Oscal. The visit report of 04/18/08, the nurse documented that the patient was started on Aricept 5 mg po QHS (orally every night). The nurse failed to document the pre pour of the Oscal on 04/09/08. The nurse failed to document the pre pour of Oscal and Aricept on	H 618	Patient # 6 : I) MD orders for period 12/10/07 to 6/10/08 state "RN Q Weekly prepour medications" with medications listed under medication heading. On 5/22/08 an Interim order was sent to the Primary MD reflecting the addition of Aricept to pt's medications as of 4/18/08. This order was returned signed by the MD and dated 5/27/08. II) 100% focused audit comparing medications listed on MD orders and those documented in the RN report is being conducted on all active cases by the Clinical Manager; to be completed by 6/30/08. III) All RNs will receive in-service on documentation standards relating to prepour of medications by 6/30/08. IV) Ongoing audit of MD orders by the Clinical Manager and DPS will continue every 60 days after 6/30/08. Audit findings including compliance with MD orders standards with be reported quarterly at the PAC meetings. 6/30/08 6/12/08 Accepted	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From Page 6 04/25/08-05/15/08. On 05/21/08 at 1:30 PM, the DPS and Assistant Vice President were informed of the survey findings and were given an opportunity to provide an explanation. On 05/22/08, the Administrative staff acknowledged the survey findings. Patient #7 was admitted to the agency on 01/18/08 with diagnoses of Hypertension, Early Dementia and Depression. The Plan of Care dated 01/18 - 06/18/08 ordered the RN to pre pour medications weekly and perform medication and therapeutic diet teaching. The Plan of Care listed seventeen (17) medications that the patient was receiving such as: Toprol, Cozaar, Hydrochlorothiazide, Lasix, Potassium Chloride, Lexapro, Citracal + Vitamin D, Aspirin, Protonix, Lipitor, Coumadin, Slow Magnesium, Aricept, Valium, Amoxicillin, etc. Review of the Skilled Nurse (SN) visit notes dated 01/19, 01/25, 02/01, 02/08, 02/15, 02/22, 02/29, 03/07, 03/14, 03/21, 03/27, 04/03, 04/10, 04/17, 04/24, 05/02 an 05/07/08 consistently documented that the nurse pre poured the medications but lacked documentation of the medications name, dosage, and the frequency. On 05/21/08 at 1:30 PM, the Director of Patient Services (DPS) and Assistant Vice President were informed of the survey findings and were given an opportunity to provide an explanation. On 05/22/08, the Administrative staff acknowledged the survey findings.	H 618	Patient # 7: II) The Clinical Manager will review all RN visit reports on a weekly basis to ensure documentation standards are maintained with regard to medication name, dosage, frequency and route of administration. This procedure has commenced 6/2/08. III) All nurses will be educated on standards for maintaining patient records according to guidelines by 6/30/08. IV) On-going focused audits by the Clinical Manager and DPS of RN visit reports will begin by 6/30/08 with follow-up every 60 days. Accepted 6/13/08	6/30/08

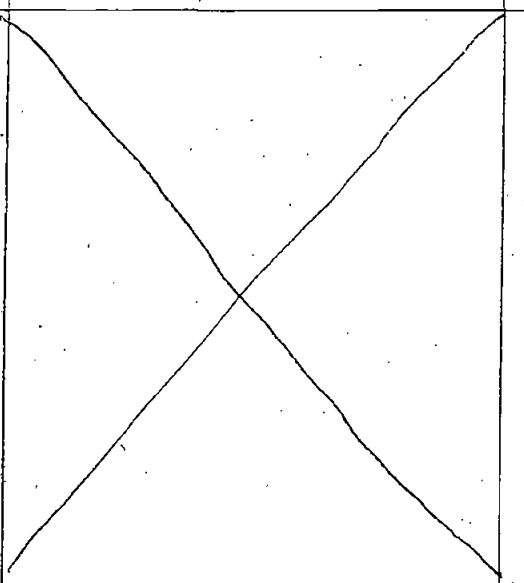
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES. INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 7 766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Rule is not met as evidenced by: Based on review of the Home Health Aide Training Program (HHATP) trainee files and staff interview, the Governing Authority failed to ensure that the HHATP maintain sufficient documentation to demonstrate that the requirements of the standard are met in five (5) out of five (5) trainee files reviewed. The Governing Authorities failure to ensure that the HHATP maintain sufficient documentation to demonstrate the standards are met places the HHATP at risk for inadequate training of home health aides. Findings include: Review of trainee files #1 thru #4 documented that the trainees completed the HHATP on 03/03/08. Review of trainee file #5 documented that the trainee completed the HHATP on 10/08/07. The trainee files for trainees #1, #2, #3, #4 and #5 lacked documentation of the number of	H1002 H1002	H1002 Home Health Aide Training Program I. Attendance sheet will document the number of hours of classroom, testing and S.P.T hours to comply with certification criteria. See attachment A. (Training Program Attendance sheet) II.A new attendance sheet has been instituted to identify program hours. See attachment A III. Revisions to attendance scheduled hours will be monitored on a monthly basis IV. To ensure best practice: the revisions to the attendance "sign –in" sheet will be identified at Selfhelp's quarterly Home Health Aide Training program Professional Advisory Committee. Accepted 6/13/08	7/1/08

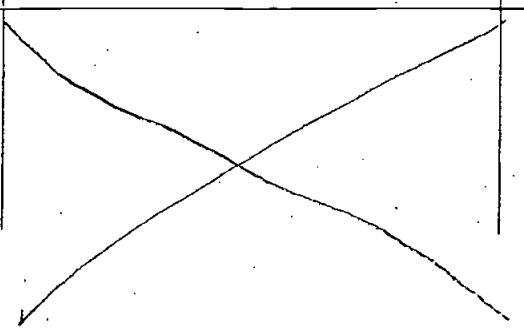
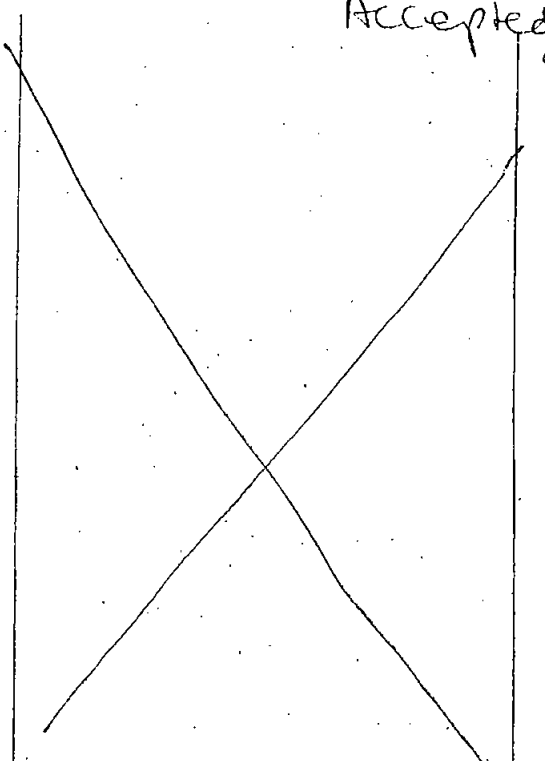
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From Page 8 trainee hours received: The files contained only documentation of the sixteen (16) Supervised Practical Training (SPT) hours received. Further review of the "HHATP Training Program Attendance" sign-in sheet lacked documentation of the time trainees arrived to class and time trainees left class. The record lacked documentation of the number of hours in classroom training received. An interview was conducted with the Assistant Vice President of Home Care, Director of Patient Services, and the Clinical Manager on 05/22/08 at 01:30PM, they acknowledged the survey findings.	H1002		
H1014	766.9(g) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (g) employ or contract for a sufficient number of staff to coordinate, direct and deliver services to patients accepted for care in accordance with prevailing standards of professional practice. This Rule is not met as evidenced by: Based on request for personnel/contracts for services available by the agency and staff interview, the agency failed to employ or contract for sufficient staff to ensure the delivery of services identified on the agency's license. The agency's failure to employ or contract staff to provide the services on the license places the patients at risk for not having their Medical Social Work (MSW) needs met.	H1014	I. MSW will be put into place and the employee file 7/21/08 Will be compliant by 7/21/08 II. An existing Selfhelp Community Services, Inc Social worker is in place with a verified active license And registration, remaining components of employee file To be completed by 7/21/08 III. The calendar month of June will be a guideline to keep The employees file in compliance. IV.A monitoring system in collaboration with our Human resources .Will flag employees file for compliance. Accepted 6/13/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1014	Continued From Page 9 Findings are: Review of the agency license included MSW as a service that the agency is able to provide. An interview with the Director of Patient Services (DPS) on 5/22/08 at 1:40 PM, the DPS stated that the agency does not have an employee or contract to provide MSW services to the patients.	H1014		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of	H1142	See page 11 for Plan of Correction Related to H1142 — POC Reviewed Accepted 6/13/08 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES. INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From Page 10 the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Rule is not met as evidenced by: Based on request for the agency's policy and procedure, and staff interview, the Governing Authority (GA) failed to establish written policies and procedures defining the agency's Health Providers Network (HPN) coverage. The GA's failure to establish and maintain an HPN policy and procedure places the agency at risk for poor patient care practice. Findings include: On 05/21/08 the surveyor requested a copy of the HPN policy and procedure. The Director of Patient Services reported that the agency does not currently have a policy and procedure on HPN. On 05/22/08 at 02:00PM, the DPS acknowledged the survey findings that the agency is operating without the requirement of an HPN policy and procedure.	H1142	H1142 Policy and Procedures HPN network I. The Policy and Procedure for the Health Provider Network will be in place 7/30/08 II. The policy will be in place and revised annually or as necessary required by the standards of the Dept of Health. III. The review of policy and procedures by the Corporate Compliance department annually. IV. Review of Health Provider Network on a daily basis. Accepted 6/13/08	7/30/08

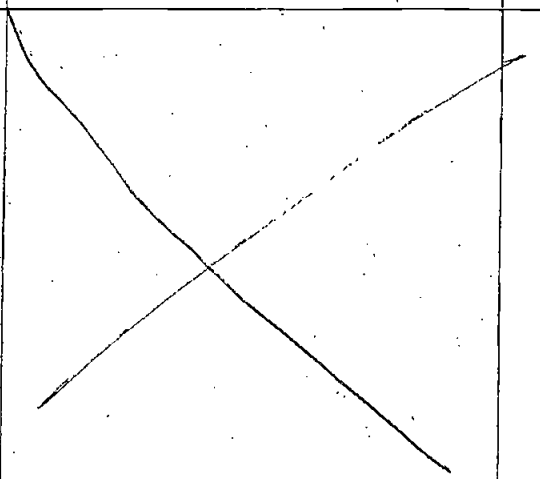
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES. INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1350	Continued From Page 11	H1350	I. In –Home annual performance is in place and completed by 6/5/08	6/5/08
H1350	766.11(k) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (k) that an annual assessment of the performance and effectiveness of all personnel is conducted including at least one in-home visit to observe performance, if applicable. This Rule is not met as evidenced by: Based on review of personnel files and staff interview, the agency failed to ensure that all health care personnel receive an annual assessment of the performance and effectiveness which includes at least one (1) in-home visit to observe performance. This was evident in two (2) of two (2) professional employees that required annual performance evaluations. (Employees #4, and #5) The agency's failure to ensure that all employees receive annual performance evaluation including in home visit observation places the patients at risk for receiving poor quality care. Findings are: Review of personnel file of Employee #4 included an annual Employee Performance Appraisal for years 2006 and 2007 but lacked evidence of in-home visit observation. The employee has been employed with the agency since January 11, 1996. Review of personnel file of Employee #5 included an annual Employee Performance Appraisal for year 2006 but lacked evidence of in-home visit observation and lacked annual evaluation for	H1350	II. Annually in June field staff will be assessed for their field evaluations. III. In order to ensure that clinical evaluations and employee appraisals are completed guidelines are in place for the calendar month June utilizing the same time sequence as the organization's employee appraisal sequence. IV. The new guidelines for clinical evaluations are in place . Accepted 6/13/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0308L001	A. BUILDING _____ B. WING _____	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES, INC.	50 CLINTON STREET HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1350	Continued From Page 12 year 2007, which was due in July of 2007. The employee has been employed with the agency since 02/18/04. On 05/22/08 at 10:00 AM, the Director of Patient Services (DPS) and Assistant Vice President were informed of the survey findings. The DPS acknowledged the findings and stated that the nurses are evaluated in the field but acknowledged that the files lacked documentation of the in-home observations.	H1350		

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L007	A. BUILDING _____ B. WING _____	07/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES	696 DUTCHESS TURNPIKE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments An Article 36 survey was conducted at the agency on 7/8/08 and 7/9/2008. Ten (10) patient care records were reviewed (Patient #1through #10) including two (2) home visits (Patient #4, #8). Ten (10) personnel files were reviewed (Employee # 1 through #10).	H 000		
H 404	766.3(b) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This RULE is not met as evidenced by: Based on record reviews and interview, the agency failed to ensure that Plans of Care (POC) were complete and identified all care needs. This was evident in four (4) of ten (10) patient care records reviewed. (Patient # 1, 8, 9, and 10). Failure to ensure and through and complete POC which addresses all patient needs has the potential for patient needs to go unmet. The findings include: 1) Patient #1 has a start of care of 2/28/08 with	H 404	**I. Corrective action for those patients found to be affected by the deficient practice:** Patient #1: The patient's physician will be contacted regarding the change in the plan of care and orders obtained. Patient #8: A new POC will be written to reflect the HHA service times and hours. The new POC will be sent to the patient's physician for approval. Patient #9: A new POC will be written to reflect the HHA service times and hours. The new POC will be sent to the patient's physician for approval. Patient #10: A new POC will be written to reflect the HHA service times and hours. In addition, the patient's physician will be notified of the skin tear and if it remains unhealed, treatment orders will be obtained. The new POC will be sent to the patient's physician for approval.	8/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L007	A. BUILDING _____ B. WING _____	07/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES	696 DUTCHESS TURNPIKE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 1 diagnoses which include UTI (urinary tract infection), Hypertension and Dementia. The nursing note dated 4/5/08 documents a telephone call between the nurse and the patient's primary caregiver stating "patient was/is constipated." "Instructed re: purchase glycerin suppository since that has been successful in the past." There is no documentation to reflect the patient's physician was notified of this modification to the POC. 2) Patient #8 has a start of care of 1/2/07 with diagnoses which include Generalized Osteoarthritis and Congestive Heart Failure. The POC dated 6/28 through 12/25/08 documents: "supervise HHA" (Home Health Aide) "assist with ADL" (activities of daily living). The POC lacks documentation to reflect the times and hours the HHA is to work. 3) Patient #9 has a start of care of 1/17/07 with diagnoses which includes Alzheimer's Disease. The POC dated 7/18/08 documents: "supervise HHA". The POC lacks documentation to reflect the times and hours the HHA is to work. 4) Patient #10 has a start of care of 5/1/07 with diagnoses which include CVA (Cerebral Vascular Accident) and Hypertension. The POC dated 5/12/08 documents: "supervise HHA to assist with ADLS, safety. The POC lacks documentation to reflect the times and hours the HHA is to work. The nursing visit note dated 9/6/07 documents: "	H 404	**II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** All private pay and case managed patients have the potential to be affected by the deficient practice. These applicable clinical records will be audited by the Office Administrator and Field Nurse Supervisor to determine compliance with the regulation. For the patients found to be out of compliance, the Field Nurse Supervisor will develop a new plan of care and send them to the patients' physicians for approval. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** All Field Nurse Supervisors will be in-serviced on Policy 11.6 by the Office Administrator or Regional DPS which directs nursing staff to conduct home visits for reassessment as needed, but in no case, not less than every 6 months. In addition, they will also be in-serviced on the necessity of updating plans of care/treatment when there are any changes, including but not limited to service times and hours change. The nurses will be instructed that the patient's physician must be notified of any changes.	

NYS Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1086L007	A. BUILDING _____ B. WING _____	07/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES	696 DUTCHESS TURNPIKE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From Page 2 left buttock skin tear Neosporin applied" There was no documented evidence that the physician was notified of this modification of the POC. During interview with the agency Administrator on 7/9/08 at 11:45AM the Administrator stated the nurses "should have" documented the frequency for the HHA's on the POC and "notified the patient's physician's of treatments."	H 404	**IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** 10% of the private and case-managed records will be audited each quarter for a one year period to ensure compliance with the regulation. The Regional DPS and Regional Vice President will review the audits every quarter to ensure compliance with the regulation. Persons responsible for the correction and on-going compliance are: Field Nurse Supervisors (FNSs) Office Administrator Regional DPS (Director of Patient Services) Regional Vice President Date of Correction: 12/09/08	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337290	A. BUILDING _____ B. WING _____	C 08/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES INC. & CHHA	5923 STRICKLAND AVENUE BROOKLYN, NY 11234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS A complaint investigation was done on 08/27/08 for Complaint # NY00061500. Three patient records were reviewed and are identified as Patient 1-3.	G 000		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to provide treatment as ordered. This was evident for 1 of 3 sampled patients. (Patient #1) Failure to follow treatment order has the potential for substandard patient care. The finding is: Patient # 1 was admitted to the Home Health Agency on "3/25/08" with a diagnosis of Senile Dementia, Hypertension and Diabetes. The Physician order dated 7/17/08 documents an order for the patient to receive physical therapy. The patient care record documents that the agency did not sent a physical therapist to evaluate the patient until "8/8/08". On 8/27/08, the Director of Patient Services was interviewed and stated that the agency "does not have" a valid reason for the delay in physical therapy services.	G 165	Corrective Action Upon further investigation the physician had postponed physical therapy due to the patient not being able to tolerate active therapy. The Case Manager was issued a disciplinary warning for failure to document timely in the medical record and failure to obtain an interim order. Measure to promote systemic changes and monitoring to ensure deficient practice will not occur. The case managers were assigned to teams according to geographic area. Each geographic area has a designated Supervisor. The Supervisor will complete periodic chart audits on all patients receiving ancillary services including physical therapy to ensure that physician orders are current and that the documentation supports the need for continued therapy. Requests for physical therapy are being centralized and a clerk has been assigned to ensure that all referrals are placed timely.	08/27/08 02/01/09 08/27/08
G227	484.36 © (2) ASSIGNMENT AND DUTIES OF HOME HEALTH AIDE	G227	Patient #1 -The DPS did an investigation regarding the training of both HHA's. Both HHA's received their Certification from Bronx Institute.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337290	A. BUILDING _____ B. WING _____	08/27/09

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES INC. & CHHA	5923 STRICKLAND AVENUE BROOKLYN, NY 11234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued from page 1 HOME HEALTH AIDE Any home health aide services offered by an HHA must be provided by a qualified home health aide. This STANDARD is not met as evidenced by based on record review and interview, the agency failed to assign a trained Home Health Aide skilled in Hoyer lift usage. This was evident for one of three sampled patients (Patient # 1) Failure to ensure the skills of a Home Health Aide (HHA) places the patient at risk for substandard care. The finding is: 1. Patient # 1 was admitted on "3/25/08" with a diagnosis of Senile Dementia, Hypertension and Diabetes A complaint received by the NYSDOH (New York State Department of Health) dated 8/18/08 alleges that the "HHA did not know how to use the Hoyer lift on Sunday 8/17/08" The patient care record documents that the patient is incontinent of urine and feces; requires total assistanve in all areas of daily living non-ambulatory and requires a Hoyer lift for transfers from bed to chair. The supplemental patient care plan dated "5/26/08" documments that the patient is to be transferred using a "Hoyer lift". The patient care plan dated 5/26/08 contains a note which documents.....home health aides are	G 227	The DOH Certification curriculum clearly indicates that transfer training and use of the hoyer lift be satisfactorily completed and demonstrated in order to obtain Certification. *(See attachment #1)* Both aides received their Certificatton (2005 & 2007) indicating that they did have training and successfully completed a return demonstration. *(See attachment # 2 & 3).* Since the complaint both aides have undergone further training on the hoyer lift. At the request of the CHHA all HHA's placed on cases must have a transfer /hoyer lift re-training done on an annual basis as part of their annual in-service requirements. In order to ensure continued compliance the Case Managers are required to update the HHA Plan of Care every 60 days or more frequently if changes occur. **Responsible Person:** RN/Case Manager will update HHA POC every 60 days. The Nurse Supervisor & DPS will ensure Care Plan is updated by performing chart review. All active patients that have a hoyer-lift in the home the aides will have re-training in the proper use , techniques and transfers using the hoyer lift. The RN will document in her supervisory note that the aides satisfactorily completed a returned demonstration. *(See attachment # 4)* **Responsible Person:** RN assigned to the case will supervise HHA's using hoyer lift., and document in the nurses visit note. Americare's DPS will ensure supervision occurs. **Measure to promote systemic changes and monitoring to ensure deficient practice will not occur.** Americare Inc. HHA's with Certificates from Bronx Institute will under go training and a return demonstration on use of the hoyer lift.	08/17/08 12/31/08 & ongoing 12/02/08 & ongoing 12/2/08 & ongoing 12/31/08 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337290	A.BUILDING _____ B. WING _____	08/27/08

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES INC. &CHHA	**5923 Strickland Ave Brooklyn, NY 11234**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 277	Continued From page 2 to be instructed and supervised with return demonstration of these duties..... The agency HHA schedule dated 8/17/08 documents that a Home Health Aide was assigned to care for the patient. The personnel record of the Home Health Aide assisgned on 8/17/08 does not include documentation fo training for Hoyer lift usage in patient transfers. On 8/27/07 at 12pm, the Director of Patient Services was interviewed and stated that there was nothing to indicate that the Home Health Aide has been instructed and/ort supervised in Hoyer lift usage. The home health aide was not available for interview.	G 277	**Measure to promote systemic changes and monitoring to ensure deficient practice will not occur.** On an annual basis all active HHA's will be required to undergo training in transfers and the use of Hoyer lift as part of their in-service hours. **Responsible Person**: Americare Inc. in-service educators, QI Director and Administrator will ensure retraining is completed on an annual basis.	12/31/08 & ongoing

ATTACHMENT #1

Guide to Home Health Aide Training
And Competency Evaluation

INTRODUCTION

The purpose of this Guide is to clarify for certified home health agencies (CHHAs), long term home health care programs (LTHHCPs), licensed home care services agencies (LHCSAs), and hospices, hereafter referred to as home care agencies, the New York State home health aide training and evaluation requirements, and the process and procedures for Department of Health approval of home health aide training programs. Effective October 1, 2006, any applicant seeking initial approval of a home health aide training program or any existing approved program seeking reapproval must comply with the requirements set forth in this Guide. These requirements supersede the requirements set forth in the New York State Department of Health's Guide to Home Health Aide Training and Competency Evaluation (1992).

The training and evaluation requirements and approval process set forth in this guide are consistent with Part 484 of Title 42 of the Code of Federal Regulations (42 CFR) and Section 700.2 of Title 10 of the New York Code, Rules and Regulations (10 NYCRR). In order to provide home health aide services in New York State, a person must successfully complete a training and competency evaluation program or competency evaluation program only conducted by an approved home health aide training program.

TRAINING REQUIREMENTS

A home health aide training program must include classroom and supervised practical training. The aide trainee must receive a minimum of 75 hours of training including 16 hours of supervised practical training. Supervised practical training means training in a laboratory, patient's home or other health care setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse. At a minimum, fifty percent (50%) of each aide's supervised practical training must be provided in a patient care setting. The setting(s) used for practical training and the number of training hours provided should be based on each student's learning needs.

CURRICULAR CONTENT

Each home health aide training program must identify and clearly state its goals and objectives and must include measurable performance criteria specific to both the curricular subject material and clinical content required by the Department. We recommend that the curriculum be taught at a sixth grade reading level. The curriculum must include the content outlined below:

1. Orientation to home care and the role of home health aides;
2. understanding basic human needs of individuals and families including understanding the elderly, infants and children, persons with physical illnesses, persons with physical disabilities and persons with mental disabilities;
3. communication skills;
4. basic elements of body function;
5. patient rights and HIV confidentiality;
6. safety, accident prevention and responses to emergencies;
7. infection control and universal blood and body fluid precautions;
8. personal hygiene and grooming including bed, sponge, tub or shower baths; skin, tub or bed shampoos; nail and skin care; oral hygiene; toileting and elimination;
9. use of prescribed medical equipment and supplies;

10. rehabilitation including safe transfer techniques and ambulation; normal range of motion and positioning; assistance with use of crutches, walkers, and hoyer lifts; and prescribed exercise programs;
11. nutrition and fluid intake, to include preparation of meals for simple and complex modified diets;
12. temperature, pulse, respiration, and blood pressure;
13. simple test and measurements;
14. maintaining a clean, safe environment;
15. assistance with medication administration;
16. special skin care;
17. simple dressing changes;
18. ostomy care;
19. handling patient's money; and
20. observing, reporting, and recording.

The training program's teaching staff may exercise discretion in determining the amount of time required to adequately teach each of the subject areas, however, the minimum training time required must be met for each subject area and the training hours must total a minimum of 75 hours.

STANDARDIZED TRAINING CURRICULA

In order to assure that all home health aide training programs are teaching comparable content, home health aide training programs are required to use this curricula as the basis for the home health aide training program.

The revised objectives and outline must be followed and all material must be covered.

The Home Care Core Curriculum (HCCC) and the Health Related Task Curriculum (HRTC) developed in 1992 by the State University College of Buffalo under contract with the State Department of Social Services (SDSS) may be used as an adjunct to the information contained in the revised objectives and outline. These curricula may be obtained from:

Health Education Services
P.O. Box 7126
Albany, NY 12224
(518) 439-7286 fax: (518) 439-7022
www.hes.org

Other resources may be used at the discretion of the Registered Professional Nurses supervising the approved Personal Care Aide/Home Health Aide Training Programs.

Training programs should supplement to standardized curricula with other training materials as necessary to provide adequate instruction in the curricular content outlined on pages 1 and 2 of this Guide. For example, the above curricula should be supplemented to address patient rights, HIV confidentiality and universal blood and body fluid precautions, (items 5 & 7 of the curricular outline). Therefore, training programs are required to use Part 63 or 10 NYCRR (Confidentiality of HIV-related information); Sections 763.2, 766.1, or 794.1 of 10 NYCRR, (Patient rights concerning CHHA; LTHHCP, LTHHCP and hospices respectively); and the Department of Health Memorandum 90-1 (Recommendations for the Prevention and Management of Bloodborne Disease Transmission in Home Care Settings) in the instruction of these topics.

COMPETENCY EVALUATION PROGRAM

The home health aide training program is also responsible for ensuring that each home health aide trainee is competent in each skill and procedure taught in the training program. Competency evaluation may be integrated throughout the training program or may be conducted subsequent to classroom and supervised practical training. Initial competency must be evaluated by a registered nurse using the following methods:

- written and/or oral examinations that demonstrate the aide's knowledge of the information presented in the classroom training; and
- observation and demonstration by the aide of his/her competency in performing skills in the laboratory or patient care setting. The tasks associated with personal hygiene, rehabilitation and vital signs (the subject areas listed in items 8, 10 and 12 of the curriculum outlined on page 2 of this Guide) must be evaluated after observation of the aide's performance of the task with a person in the laboratory or patient care setting during the supervised practical training.

To evaluate each home health aide trainee's competence in performing the minimally required number of home health skills, each home health aide training program should utilize the following:

- The written unit tests found on the Health Department's Health Provider Network; and

- The skills checklists found in the appendices of the Home Care Curriculum (HCC) and the Health Related Tasks Curriculum (HRTC).

A home health aide training program may also supplement the written unit tests and performance examinations contained in the HCC and HRTC with evaluation processes developed by training programs to assure that the aide is competent in the content and skills learned throughout the training program.

For each home health aide who has completed classroom and supervised practical training, all competencies must be documented on a competency evaluation form developed by the home health aide training program and approved by the Department of Health. The competency evaluation form must list the competencies which are subject to evaluation; the method of evaluation and the satisfactory or unsatisfactory outcome of the evaluation; and the identity, by name and license number, of the registered nurse who has evaluated the aide's performance of each task. Classroom and supervised practical training and competency evaluation must be completed within two months of each aide's entry into the training program.

COMPETENCY EVALUATION ONLY

In lieu of the standardized training and competency evaluation, the home health aide training program must make available to eligible individuals a competency evaluation program only. The competency evaluation program should be derived from the written unit tests and skills demonstration checklists included in the HCC and HRTC curricula. The written and skills demonstration portions of the competency evaluation program must contain sufficient content to assure that the aide is competent in the information and skills set forth in the curricular outline on pages 1 and 2 of this Guide. The subject areas listed in items 8, 10, and 12 of the curricular outline must be evaluated after observation of the aide's performance of the task with a person in the laboratory or patient care setting.

Individuals eligible to complete the competency evaluation program only, in lieu of training, include:

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office
90 Church Street New York, NY 10007

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

February 6, 2009

Gentiva Health Services
Attn: Mr. Keith Curtis, RN
Administrator/Dir. Clinical Operations
50 Court St., #1202
Brooklyn, NY 11201

Re: Acceptable Plan of Correction
Survey Date: January 4, 2009
License: #LC0497A

Dear Mr. Curtis:

Please be advised that the Plan of Correction relating to the recent Article 36 survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

/jt

GENTIVA®

February 3, 2009

Department of Health
Metropolitan Area Regional Office
90 Church Street
Brooklyn, New York 10007

Attn: Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Healthcare & Hospice Services

Survey: Re: Gentiva Health Services
License Number LC0497A
Survey date: 1/14/09

Dear Ms. Phoenix-Tannis:

Please see the amended Plan of Correction and attachments developed in response to the summary statement of deficiencies for the Article 36 survey.

Please contact me at 718-237-2389 if you have any questions related to this response.

Sincerely,

Keith Curtis RN
Administrator/Dir. Clinical Operations

RECEIVED
FEB 02 2009

50 court st. • #1202 • brooklyn, ny 11201 t 718.237.2389 • f 718.237.0632 www.gentiva.com

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State Relicensure Survey was conducted at Gentiva Health Services on January 14, 2009. Five (5) Patient Care Records were reviewed and are identified as Patients #1 to #5. Four (4) Personnel Records were reviewed and are identified as Employees #1 to #4. The agency Policy and Procedure Manual, Quality Improvement Committee Meeting Minutes, Complaint Log and Admission Packet were reviewed.	H 000	**H 204 766.1 (a) (1) PATIENT RIGHTS** For the patient found to be deficient in obtaining the correct consent on admission, the Area Director immediately contacted the patient and obtained informed consent with updated consent addenda. To identify other patients who may have potentially been affected by this, 100% of Licensed Agency patients clinical records were immediately audited for consents matching services ordered and provided during that certification period by the Area Director. This was completed by 1/16/09. The Area Director (AD) and Area Clinical Specialist (ACS) will provide re-education on proper procedures for completing consent including the correct frequency and duration of expected services. This education will be competed on 1/29/09 at mandatory staff meeting. In an effort to make sure the deficient practice is not repeated, the agency will audit 100% of all licensed agency records from admission date for compliance with completing consent information with correct expected frequency of services to be provided, and if a need is present for an alteration in the plan, an consent addenda for the corrected and agreed upon frequency and duration will be completed.	
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges; (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient.	H 204		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 1 (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure all patients are informed of any changes in services and payment. This was evident for one (1) of five (5) patient care records reviewed. (Patient #3.) Failure to ensure all patients are informed of any changes in services and payment places patients at risk for not being able to fully exercise all of their rights. The finding is: Patient #3 has diagnoses which include: Leukemia, Pulmonary Embolism, Diabetes Mellitus and Acute Pericarditis. The patient care record includes a "Home Care Consent" which documents the following information: "The services which Gentiva Health Services will provide for me are indicated below. Skilled Nurse 1 x/wk for 1 week (skilled nurse once a week for one week.) . . . Expected charges $198.00 per visit." The patient care	H 204	The agency will continue to monitor compliance in this effort with ongoing audits of 100% of all Licensed Agency clinical records for compliance with the consents matching the physician ordered plan of care. For any alteration in the plan of care, the clinician will obtain consent addenda to validate the agreement and patient responsibility. Results of the ongoing audits will be collected and reported to the PI and PAC committee quarterly. Responsible party(s): AD; ACS.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 2 record documents more than one visit by the nurse. There is no documented evidence of a "Home Care Consent" which informs the patient of the change in services. On January 14, 2009 at 1:35 PM, the Assistant Director was interviewed and did not provide an explanation.	H 204		
H 324	766.2(a)(9) Patient service policies and procedures 766.2 Patient service policies and procedures. (a) The governing authority shall ensure for each health care service provided that: (9) a patient is discharged by the agency after notification of the authorized practitioner, as defined in subdivision (b) of section 766.4 of this Part, and consultation with the patient and any other professional staff involved in coordinating the plan of care, no less than 48 hours prior to patient discharge. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure authorized practitioners are notified no less than 48 hours prior to a patient's discharge. This was evident for two (2) of five (5) patient care records reviewed. (Patients #4 and #5.) Failure to to ensure authorized practitioners are notified no less than 48 hours prior to a patient's discharge places patients at risk for poor continuity of care. The findings are: 1) Patient #4 has diagnoses which include:	H 324	**H324 766.2 (a) (9) PATIENT SERVICE POLICIES AND PROCEDURES** The Area Director and Area Clinical Specialist will provide a mandatory staff meeting regarding compliance with this regulation on 1/29/09. A review of 100% of the Licensed Agency clinical records that were discharged in 4th quarter 2008 will be completed by 2/27/09. All of the patient's physicians will be contacted regarding the discharge of the patient from service and the disposition of the patient at discharge if there is no evidence of physician contact in the record. 100% of all Licensed Agency clinical records will be audited prior to discharge with a mandatory case conference with the MCP to ensure compliance with this regulation and to prevent recurrence of this deficient practice.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST.. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 324	Continued From page 3 Revised Hip Replacement, Hyperlipidemia and Osteoarthritis. The patient care record documents a discharge date of "2/19/08". There is no documented evidence on the discharge summary of physician notification. 2) Patient #5 has diagnoses which include: Non-Healing Surgical Wound. The patient care record documents a discharge date of "2/11/08". There is no documented evidence on the discharge summary of physician notification. On January 14, 2009 at 1:35 PM, the Assistant Director was interviewed and did not provide an explanation.	H 324	Part of the focused clinical record audit will include audit for compliance with this regulation. 100% of all discharged Licensed Agency clinical records will be audited for compliance. This information will be reported to the PI committee and PAC Committees quarterly. Responsible party(s): AD; ACS; MCP	
H 408	766.3(d) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months; (1) each review shall be documented in the clinical record; and (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care.	H 408	**H408 766.3 (d) PLAN OF CARE** For the patient found to be deficient in Complete plan of care matching the ordered frequency of professional services to the provided frequency of professional services, the Area Director immediately obtained signed orders form the physician for the visits completed 11/6/08-11/9/08, patient was hospitalized 9/12/08-11/5/08 The clinician immediately contacted the physician regarding the correct frequency the visits were planned for and obtained orders for visits completed and omitted in error on completion of the plan of care.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From page 4 This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure the plan of care is revised as necessary and the authorized practitioner is informed of the need to change the plan of care. This was evident for one (1) of five (5) patient care records reviewed. (Patient #3.) Failure to ensure the plan of care is revised as necessary and the authorized practitioner is informed of the need to change the plan of care places patients at risk for receiving poor quality care. The finding is: Patient #3 has diagnoses which include: Leukemia, Pulmonary Embolism, Diabetes Mellitus and Acute Pericarditis. The patient care record includes a "Home Health Certification and Plan of Care" dated "09/11/08 to 11/09/08" which documents orders for: "SN 1 X WK X 1 WKS" (Skilled Nurse once a week for one week). The patient care record documents more than one visit by the nurse. There is no documented evidence of a revised plan of care and the physician was informed of the need to change the plan of care. On January 14, 2009 at 1:35 PM, the Assistant Director was interviewed and did not provide an explanation.	H 408	In an effort to prevent the same deficient practice with other Licensed Agency patients, 100% of all Licensed Agency clinical records will be audited for compliance with orders of services matching services provided by 2/27/09. The Area Director and Area Clinical Specialist will re-educate the staff on compliance with providing services as ordered at a mandatory staff meeting on 1/29/09. Ongoing audits of 100% of all Licensed Agency clinical records will be reviewed for compliance of ordered frequency matching provided frequency. This information will be presented to the PI and PAC Committees quarterly. Responsible party(s): AD; ACS	
H 512	766.4(c) Medical Orders 766.4 Medical orders. (c) Such orders shall be reviewed and revised as	H 512	**H512 766.4 (c) MEDICAL ORDERS** For the clinical records identified as not having a current physician order,	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 512	Continued From page 5 the needs of the patient dictate but no less frequently than every six months, except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid patient This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure that medical orders are reviewed and revised every six months. This was evident for three (3) of four (4) patient care records reviewed. (Patients #1, #2 and #3.). Failure of the agency to ensure that medical orders are reviewed and revised every six months places patients at risk for not being under the care of an authorized practitioner. The findings are: 1) Patient #1 has diagnoses which include: Total Hip Replacement and Hypertension. The patient care record documents a medical order dated: "11/15/08 to 1/13/09". There is no documented evidence of medical orders dated after "1/13/09". 2) Patient #2 has diagnosed which include: Brain Injury and Chronic Pain. The patient care record documents a medical order dated: "09/09/08 to 11/07/08". There is no documented evidence of medical orders dated after "11/07/08". 3) Patient #3 has diagnoses which include: Leukemia, Pulmonary Embolism, Diabetes Mellitus and Acute Pericarditis. The patient care record documents a medical order dated: "9/11/08 to 11/09/08". There is no documented evidence of medical orders dated after	H 512	these records have had the orders re-sent to the physicians, followed up with a phone call to their offices and have all been signed and placed in the clinical records. 100% of all active Licensed Agency clinical records have been reviewed for compliance with current clinical orders in the records. This was accomplished by 1/16/09 by the Area Director. In an effort to prevent this practice from reoccurring, the MCP and clerical staff has been re-educated on the process of paper flow in the office from SOC to creating the clinical record, including the review of the SOC documents and creating of the Plan of Treatment for the physician to sign. This was completed on 1/16/09. 100% of all Licensed Agency clinical records will be audited for compliance with current physician Plans of Treatment. This information will be collected and presented to the PI and PAC Committees quarterly. Responsible party(s): AD; MCP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 512	Continued From page 6 "11/09/08". On January 14, 2009 at 3:45 PM, the Assistant Director was interviewed and stated: "Those doctors orders are floating around here somewhere. I'm not sure why they were not filed."	H 512		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure all medical orders are signed by the authorized practitioner within 30 days. This was evident for three (3) of five (5) patient care records reviewed. (Patients #3, #4 and #5.) Failure to ensure all medical orders are signed by the authorized practitioner within 30 days places patients at risk for receiving unauthorized care. The findings are: 1) Patient #3 has diagnoses which include:	H 514	**H514 766.4 (d) MEDICAL ORDERS** On the clinical records identified as not having the orders signed in 30 days, these records have had the orders re-sent to the physicians, followed up with a phone call to their offices and will all be signed and placed in the clinical records. The clerical and clinical staff will be re-educated at a mandatory staff meeting on 1/29/09 regarding this regulation and compliance. For physicians identified without signature after multiple calls by the clerical support staff, and the AD, a copy of the order will be brought to the office by the Account Executive (AE) for signature in person. This will be ongoing until all competed and signed. Going forward, 100% of all Licensed Agency clinical records will be reviewed for compliance with orders signed, and dated in 30 days of the order. Staff will have been re-	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 7 Leukemia, Pulmonary Embolism, Diabetes Mellitus and Acute Pericarditis. The patient care record documents medical orders for occupational therapy dated "12/15/08" and "11/12/08" by the occupational therapist, which do not include documented evidence of a physician's signature. The patient care record documents telephone orders dated "12/12/08", "11/24/08", "1108/08" and "11/6/08" by the nurse. The orders do not include documented evidence of a physician signature. 2) Patient #4 has diagnoses which include: Revised Hip Replacement, Hyperlipidemia and Osteoarthritis. The patient care record includes a medical order dated "02/05/08 to 04/04/08" which documents a physician's signature. There is no documented evidence of when the physician signed the order. 3) Patient #5 has diagnoses which include: Non-Healing Surgical Wound. The patient care record includes a medical order dated "02/01/08 to 03/31/08" which documents the nurse received a verbal order dated "2/1/08" for the start of care. The physician signature is documented on "4/14/08". On January 14, 2009 at 1:35 PM, the Assistant Director was interviewed and did not provide an explanation.	H 514	educated on the timeliness of the orders to be sent to the office for ability to obtain signatures dated timely at 1/29/09 staff meeting. The clerical staff members responsible for timely orders has been educated in the steps to take to obtain signatures timely, and to notify the AD if a signature is not obtained by day 21. 100% of all Licensed Agency clinical records will be audited for compliance with signed and dated physician orders. Results of the 100% audit will be tracked and reported to the PI and PAC Committees quarterly. Responsible party(s): AD, AE, clerical support staff; clinical field staff	
H1036	766.9(l) Governing authority Section 766.9 Governing authority.	H1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 8 The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure a consumer was present at the Quality Improvement (QI) Committee	H1036	**H1036 766.9 (l) GOVERNING AUTHORITY** The QI membership will include two (2) consumer members to ensure the presence of one at each QI meeting going forward. The consumer will be notified in advance of the scheduled meeting for ability to accept the position on the committee. This Agency understands the importance of compliance with regulatory guidelines and the importance of maintaining quality services and adequate care. The QI committee will be complete with all members as dictated by the regulation. Two consumers have been identified and agreed to the role of consumer for the QI meetings with one to attend and one to be available on a coverage basis. The AD will be responsible to give ample time to notify all members of the QI Committee of the scheduled date and time of the meetings for attendance of all members. Completed and signed attendance sheets will be presented to the PAC committee quarterly. Responsible party(s): AD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 9 meetings. Failure to ensure the Quality Improvement Committee performs the required functions places patients at risk for receiving poor quality services, unsafe and inadequate care. The finding is: The QI minutes from meetings dated "5/16/08, 7/31/08 and 1/25/08" do not have documented evidence of consumer attendance. On January 14, 2009 at 2:00 PM, the Assistant Director was interviewed and stated: "We're actually getting two new consumers for that reason. So, we don't have that problem."	H1036		
H1302	766.11(a) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (a) the development and implementation of written personnel policies and procedures, which are reviewed at least annually and revised as necessary. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to revise the Criminal History Background Check Policy and Procedure. Failure to revise the Criminal History Background Check Policy and Procedure fails to inform the agency authorized person of the procedure for background checks. The finding is:	H1302	**H1302 766.11 (a) PERSONNEL** The agency has reviewed and revised it's CHRC policy (See attachment #1) to include all the recent updates, including the statement of the temporary employee will be supervised weekly pending the results of the criminal history background check. This office has not hired any paraprofessional personnel since 2005, so there are no personnel issues with the CHRC process since 2005. The policy has been updated as well as a process put in place for the occasion of a newly hired paraprofessional person. (See attachment #2)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0497A	A. BUILDING _____ B. WING _____	01/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - BROOKLYN	50 COURT ST. #1204 BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1302	Continued From page 10 The agency: "Background Investigations" does not include documented evidence of informing personnel that temporary employees are to be supervised weekly pending the results of the criminal history background check. On January 14, 2009 at 3:26 PM, the Assistant Director was interviewed and did not provide an explanation.	H1302	All staff directly involved in the hiring and supervision of the temporary employees will be educated on the policy updates at the mandatory staff meeting on 1/29/09. Quarterly reports to the PI and PAC Committee regarding the status of any temporary employee and the compliance with the supervision process until the background check is complete will be documented.	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Metropolitan Area Regional Office
90 Church Street New York, NY 10007

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

June 16, 2009

Gentiva Health Services
Attn: Michele D. Rosenblum, Administrator
50 Court Street, #1202
Brooklyn, NY 11201

Re: Response to Plan of Correction
Survey Date: May 26, 2009
License: #33-7425

Dear Ms. Rosenblum:

Please be advised that the Plan of Correction relating to the recent Recertification Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

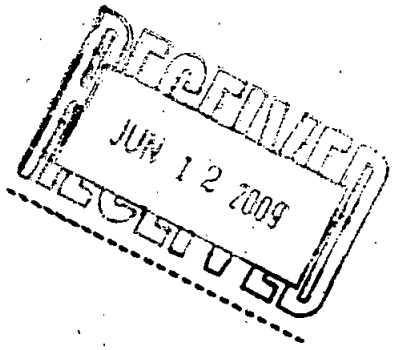
Sincerely,

C. Phoenix-Tannis M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

/jt

GENTIVA®



June 9, 2009

Ms. Cheryl Phoenix-Tannis
Program Manager, Home Health and Hospice Services
State of New York Department of Health
Metropolitan Area Regional Office
90 Church Street
New York, NY 10007

RE: Plan of Correction in Response to Re-Certification Survey
License: 33-7425
Survey Date: May 26, 2009

Dear Ms. Phoenix-Tannis,

Please find enclosed the detailed Plan of Correction in response to the survey by the Department of Health on May 26, 2009 for Gentiva Health Service, Brooklyn, NY.

If you have questions or require additional information, please contact me at 718-237-2389. We look forward to hearing from you.

Sincerely,

Michele D. Rosenblum

Michele D. Rosenblum, R.N.
Administrator
Gentiva Health Services

:EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337425	A. BUILDING _____ B. WING _____	05/26/2009

:E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
:NTIVA HEALTH SERVICES BROOKLYN	50 COURT STREET SUITE 1202 BROOKLYN, NY 11201

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
3 000	INITIAL COMMENTS A Recertification Survey was conducted at Gentiva Health Services on May 20 through May 26, 2009. Eleven (11) clinical records were reviewed and identified as Patients #1 through #11. Four (4) home visits were made to Patients #4, #5, #6 and #7. Seven (7) personnel records were reviewed and identified as Employees #1 through #7.	G 000		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the agency failed to document medications in the plan of care and maintain documentation of the medication dosage. This was evident for three (3) patients(home visits) of (11) eleven clinical records reviewed. (Patients 4 ,6 and 7) Failure to keep accurate patient medication dosage and document medications places patients at risk for medication errors and poor quality of care. The findings are:	G 337	**G337** **Corrective action for those patients found to have been affected by the deficient practice:** 1. RN case managers will reconcile medications to all medications in the home and the medication list for patients 4, 6, and 7. RN case manager will call MD and verify all medications. RN case manager will prepare revised and current medication list and forward to the MD for signature. 2. RN case manager will provide patient education on medication management, when to call the RN with changes and/or questions and document education and patient response to education in the clinical record. 3. Manager of Clinical Practice will case conference and review visit notes with RN case manger to monitor that 1 and 2 above are implemented. Manager of Clinical Practice will provide interventions and additional training if 1 and 2 above are incomplete. 4. Manager of Clinical Practice will review all visit notes for patients 4, 6, and 7 and will review medication changes with RN case manager during weekly case conference. Manager of Clinical Practice and RN case manager will reconcile medication changes to current medication list and physician orders. RN case manager will call MD with any discrepancies to verify current medications and send current medication list to MD. 5. Manager of Clinical Practice will present medication data of patients 4, 6, and 7 to the Performance Improvement Committee for review and recommendations. **Individual Responsible: Director of Patient Services** Completion Date:	6/30/2009

;ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michele D. Rosenthal	Administrator	6/9/2009

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that eguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days o y the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued igram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	337425	A. BUILOING _____ B. WING _____	05/26/2009

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
GENTIVA HEALTH SERVICES BROOKLYN	50 COURT STREET SUITE 1202 BROOKLYN, NY 11201

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 1 1) Patient #4 (Home Visit) with a start of care date of 4/30/09 with a diagnoses of Fractured Femur, Abnormal Gait, Urinary Incontinence, and Glaucoma. During a home visit on May 21,2009 the following medications were observed in the patient's home: "Nasacort (Triamcinolone Acetonide) 6.5mg two (2) sprays in each nostril at night". The clinical record dated "4/4/09 to 7/2/09 does not document the medication observed in the patient's home. On May 22, 2009 the Director of Patient Services was interviewed and stated: "the patient's wife did not mention this medication to the nurse." 2) Patient #6 (Home Visit) with a start of care date of 2/1/09 with a diagnoses of Pressure Ulcer Heel, Diabetes, Congestive Heart Failure, Hypertension, and Hyperlipidemia. During a home visit on May 22, 2009 the following medication was observed in the patient's home. "Augmentin 875mg one tab P.O twice a day". The plan of care dated "4/11/09 to 6/9/09 documents: "Augmentin 500mg PO BID". On May 22, 2009 the Director of Patient Services was interviewed and stated: " There is documentation in the patient's chart that the wife is noncompliant with the medication, we still have to check with the nurse." 3) Patient #7 (Home Visit) with a start of care date of 4/9/09 with a diagnoses of Cancer of the Esophagus, Hypertension, Abnormal Gait, and	G 337	**How will agency identify other patients baving the potential to be affected by the same deficient practice and corrective .actions to be taken?** 1. Manager of Clinical Practice will review all current patients and new admissions for the clinicians identified in the care of patients 4, 6, and 7 during a case conference, focusing on the medication lists, physician order and review of medications in the home by the RN case manager and PT. 2. Manager of Clinical Practice will document case conference and results. 3. Manager of Clinical Practice will review visit notes and focus on documentation of medication changes. 4. Manager of Clinical Practice will l randomly call patients of clinicians identified in care of patient 4, 6, and 7 to review medications and verify accuracy of medication documentation. 5. Manager of Clinical Practice will present medication data of current and new admissions for clinicians identified in the care of patients 4, 6, and 7 to the Performance Improvement Committee for review and recommendations. **Individual Responsible: Director of Patient Services** Completion Date: 7/30/2009 **What measures will be put in place and/or what systemic changes will be made to ensure that deficient practice does not recur:** 1. Director of Patient Services will train all clinical staff on medication assessment, review, coordination and documentation at the regularly scheduled staff meeting. 2. Medication review and documentation and the progress towards improvement will be standard agenda item at regularly scheduled staff meetings through the next quarter, ending September 30.2009.	

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337425	A. BUILDING _____ B. WING _____	05/26/2009

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENTIVA HEALTH SERVICES BROOKLYN	50 COURT STREET SUITE 1202 BROOKLYN, NY 11201

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 2 Hyperlipidemia. During a home visit on May 22, 2009, the following medications were observed in the patient's home: "Combigan 5ml (Brimonidine Tartrate) one drop in both eyes twice a day, Bacitracin Ophthalmic Ointment 500 units apply 1/4 inch in both eyes prn when become red". The plan of care dated: "4/9/09 to 6/7/09 does not document the medications observed in the patient's home. On May 22, 2009 the Director of Patient Services was interviewed and stated: " We have to check with the nurse. The aide accompanies the patient to his Doctors appointments and forgets to mention the additional medication to the nurse."	G 337	3. Evidence of training will be maintained in staff personnel files. 4. All PT only cases, unless otherwise ordered by the physician, will be initially assessed by and RN case manager. 5. All PT only patients' medications will be reviewed by PT and Manager of Clinical Practice and patients will be called to verify medications. If indicated, MD will be notified and sent revised medication list. **Individual Responsible: Director of Patient Services** Completion Date: **How the corrective action will be monitored to ensure that the deficient practice will not recur; i.e., what quality assurance program will be put in place?** 1. Administrator will report on the deficiencies cited during the recertification survey and the agency response at the July, 2009 Performance Improvement Committee meeting. 2. Administrator will incorporate Effective Drug Regimen Review as a standard indicator into the Performance Improvement Plan. 3. Director of Patient Services will collect Drug Regimen Review data as part of the clinical record review process and data will be presented to the Performance Improvement Committee. 4. Review and recommendations by the Performance Improvement Committee will be recorded in the minutes and presented at the staff meeting following the Performance Improvement Committee meeting in July, 2009. **Individual Responsible: Administrator** Completion Date:	9/30/2009 7/30/2009

accepted 6/16/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0806C	A. BUILDING _____ B. WING _____	10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - WHITE PLAINS	7-11 S BROADWAY #104 WHITE PLAINS, NY 10601 951IL037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State Re-Licensure survey was conducted at the agency on 9/29/09 and 10/1/09. Four (4) patient care records were reviewed and are identified as Patients #1 through #4. Eight (8) personnel records were reviewed and are identified as Employee #1 through #8.	H 000		
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and	H1036	Corrective Action Effective immediately a calendar has been established for future meetings A meeting took place on 08/04/09 and at the time of the survey the minutes had not been typed and are now attached. Effective immediately a consumer has been identified and will attend all future meetings effective with the 11/18/2009 meeting.	10/23/09 10/23/09 11/18/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director, Clinical Management — (X6) DATE: 10/23/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0806C	A. BUILDING _____ B. WING _____	10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - WHITE PLAINS	7-11 S BROADWAY #104 WHITE PLAINS, NY 10601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 1 (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record review and interview, the Governing Authority (GA) failed to ensure that the QI committee meets four (4) times a year; is attended by the required members and the committee review active patient care records, discharged patient records, and policies and procedures. Failure to ensure that the QI committee meets four (4) times a year, consists of the required members and performs the required tasks places patients at risk for receiving poor quality care. The findings are: The QI meeting minutes document the QI committee met two (2) times in 2009 and one (1) time in 2008. The QI meeting minutes document meetings on "1/29/08, 2/13/09, and 4/28/09". The QI meeting minutes dated "1/29/08, 2/13/09, and 4/28/09" lack documentation of consumer attendance. The QI meeting minutes dated "1/29/08" lacks documentation of physician attendance. The QI meeting minutes dated "1/29/08, 2/13/09, and 4/28/09" lack documentation of patients discharged from the agency and review of	H1036	The meeting of 1/29/2008 was attended by the physician who failed to sign the attendance sheet. Effective immediately all future attendance sheets will audited for physician signature. H1036 Patients discharged from the agency are identified by printing a discharge report and a clinical record review is conducted and the outcomes of the review are reported to the committee. Additionally a random selection of active patients shall be made prior to each meeting and the	10/23/09 11/18/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0806C	A. BUILDING _____ B. WING _____	10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - WHITE PLAINS	7-11 S BROADWAY #104 WHITE PLAINS, NY 10601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 2 policies and procedures. During interview with the Area Vice President (AVP) 10/1/09, the AVP did not provide the documented information and stated "the Director of Clinical Services (DCS) was working on the QA minutes..... the DCS is away on vacation".	H1036	record audited for compliance. The results of these audits will be reported to the committee	11/18/09
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health;	H1142	Policies and procedures are reviewed every quarter and have been added to the agenda as an ongoing agenda item to assure compliance with the standard H1036 On a quarterly basis the activities of the quality improvement committee will be monitored to assure compliance with: Consumer attendance Physician attendance as evidenced by signature on the attendance sheet A review of clinical record review for both discharged and active patients. A review of policies presented to review and discuss.	10/23/09 11/18/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0806C	A. BUILDING _____ B. WING _____	10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - WHITE PLAINS	7-11 S BROADWAY #104 WHITE PLAINS, NY 10601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 3 (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and staff interview, the Governing Authority (GA) failed develop a complete Health Provider Network (HPN) policy. Failure to ensure daily access to the HPN places the agency at risk for not being aware of information necessary to provide quality care. The findings are: The agency HPN policy failed to identify the following: An updated directory on HPN; A HPN policy specifying contact frequency. The agency HPN policy lacks documentation of the specific frequency of accessing the HPN by the designated agency staff. During an interview with the back up HPN Coordinator on 10/1/09, the Coordinator stated she was logging on to the HPN once a week. During the pre-survey preparation on 9/28/09, the HPN Communication Directory was accessed for the names of designated HPN Coordinator contact persons. Information obtained onsite contradicted the	H1142	H1142 Effective immediately An addendum to the disaster policy is attached for review and addresses the issues of verifying contact information and also that daily contact is made with the HPN site.	10/23/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0806C	A. BUILDING _____ B. WING _____	10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - WHITE PLAINS	7-11 S BROADWAY #104 WHITE PLAINS, NY 10601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 4 information from the HPN Directory. During an interview with the Area Vice President (AVP) on 10/1/09, the AVP did not provide an explanation for the finding.	H1142	a log has been developed and each day the designated person will sign onto HPN and sign the log indicating the same. This log is attached. Every month the HPN coordinator will sign on to the site and confirm the contact information is correct and submit this to the DOH. This process will be documented in a log which is attached. To assure there is no recurrence the logs will be reviewed monthly for compliance with the policy. Accepted Donna Sir 11/17/09	10/23/09 10/23/09 10/23/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Re-Licensure Survey and Home Health Aide Training Program (HHATP) Survey were conducted at Premier Home Health Care Services on 07/09/09 and 07/10/09. Eleven (11) Patient Care Records reviewed and identified as Patients #1 to #11. Two (2) Home Visits were made to Patients #1 and #4. Ten (10) Personnel Records reviewed and identified as Employees #1 to #10. One (1) HHATP record reviewed and identified as Trainee #1.	H 000		
H 404	766.3(b) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This Regulation is not met as evidenced by: Based on record reviews, home visits (HV) and staff interview, the home care agency failed to develop plans of care which specified the type of services home health aide (hha) or personal care aide (PCA)) to be provided to the patient. This was evident in seven (7) of eleven (11) patient care records reviewed (Patients ~~#1, #2, #3, #4,~~	H 404	**I. Corrective action for those patients found to be affected by the deficient practice:** **Patient #1 has been discharged; last day of service was 7/17/09.** **Patient #4 – Interim orders were sent to physician on identifying paraprofessional level of care as HHA.** **Patient #10 – Interim orders were sent to the physician on for signatore identifying the paraprofessional level of care as PCA.** **Patient #2 – Interim orders were sent to the physician for signature identifying the paraprofessional level of care as PCA.** **Patient #3 – Interim orders were sent to the physician for signature identifying the paraprofessional level of care as PCA.** Amended x II	7/22/09

Donna Dell, Dr — Director of Clinical Services — 8/31/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From page 1 #6, #10, and #11). Failure to ensure that the nursing staff develop the Plan of Care which specifies the type of services (hha or PCA) to be provided, places the patients at risk for unmet patient care needs. The findings are: 1) Patient #1 (HV) has an admission date of "5/30/09" with diagnoses of CAD (Coronary Artery Disease) and Renal Failure. The "Plan of Treatment" (the agency Plan of Care) dated "5/30/09 - 11/30/09" documents orders for: "HHA/PCA" (home health aide/Personal Care Aide) frequency: 5 - 7 days per week x 4 - 9 hours a day. There is no documentation to identify the level of paraprofessional services that the patient is receiving from the agency. During home visit on 7/09/09, the aide was interviewed and stated that he is working in the capacity as a home health aide on the case." 2) Patient #4 (HV) has an admission date of "05/31/07" with the diagnoses including Olivo Ponto Cerebellar Atrophy and Non-Insulin Dependent Diabetes Mellitus. The "Plan of Treatment" (the agency's Plan of Care) dated "05/31/09 - 11/30/09" documents orders for : "HHA/PCA" seven (7) days, six (6) to twelve (12) hours a day." There is no documentation to identify the specific level of paraprofessional services (hha or PCA) that the patient is receiving from the agency.	H 404	**Patient#11 – Interim orders were sent to the physician for signature identifying the paraprofessional level of care as PCA.** **Patient #6 – Interim orders were sent to the physician for signature identifying the paraprofessional level of care as PCA.** **All interim orders were sent to MD on 7/22/09.** **The Field Nurse Supervisor and Office Administrator will audit all applicable physician orders for compliance with correct identification of paraprofessional level of service and completion of the Plan of Treatment. An amendment to the POT will be sent to the physician with any items identified as missing on the POT.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients are affected by this regulation.** **1. As of 8/28/09, there are a total of 129 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. Next quarter (Oct/Nov/Dec), the agency will audit all new case managed cases going out.** **2. Based on the audit findings, if 100% are found to be complete then the audit % will be reduced to 10% quarterly.** **3. Clinical Record audit tool will be revised to reflect level of paraprofessional service indicated HHA/PCA.** Amended x 2	9/30/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From page 2 During home visit on 7/10/09, the aide was interviewed and stated that she was working in the capacity of a PCA. 3) Patient #10 has an admission date of "1/19/09" with diagnoses including Hypertension, Depression, Psychosis, and Chronic Obstructive Pulmonary Disease. The "Plan of Treatment" (the agency's Plan of Care) dated "4/27/09 - 6/26/09" includes orders for disciplines and treatment for "HHA/PCA" seven (7) days live-in services. There is no documentation to identify the specific level of paraprofessional services (hha or PCA) that the patient is receiving from the agency. 4) Patient #2 has an admission date of "12/12/08" with the diagnosis of Breast Cancer. The "Plan of Treatment" (the agency's Plan of Care) dated "06/12/09 - 12/12/09" includes orders for disciplines and treatment for "HHA/PCA" Five (5) to seven (7) days, two (2) to four (4) hours a day. There is no documentation to identify the specific level of paraprofessional services (hha or PCA) that the patient is receiving from the agency. 5) Patient #3 has an admission date of "1/02/07" with the diagnoses including Cerebral Vascular Accident and Hypertension. The "Plan of Treatment" (the agency's Plan of Care) dated "07/02/09 - 01/02/09" documents orders for: "HHA/PCA" seven (7) days live-in services.	H 404	**III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **1. The Director of Clinical Services will be responsible for overseeing the audit process and then the Office Administrator muving forward.** **2. The 485 Plan uf Treatment indicating the paraprufessiunal level of services is included in the agency RN orientation fur all new hires.** **3. Current FNS's were reoriented on the 485/Plan uf Treatment form and level of appropriate completion thereof.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **As is company practice, all new RN's will continue to be oriented to the 485/Plan of Treatment during the new hire orientation process prior to beginning field work.** **1. As of 8/28/09, there are a total of 129 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. Next quarter (Oct/Nov/Dec), the agency will audit all new case managed cases going out.** **2. Based on the audit findings, if 100% are found to be complete then the audit % will be reduced tu 10%.** Amended to 11	STANDARD PRACTICE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From page 3 There is no documentation to identify the specific level of paraprofessional services (hha or PCA) that the patient is receiving from the agency. 6) Patient #11 has an admission date of "12/12/08" with the diagnoses including Cerebral Anoxia and Depression. The "Plan of Treatment" (the agency's Plan of Care) dated "06/12/09 - 12/12/09" documents includes orders for: "HHA/PCA" four (4) to seven (7) days, four (4) to eight (8) hours a day. There is no documentation to identify the specific level of paraprofessional services (hha or PCA) that the patient is receiving from the agency. 7) Patient #6 has an admission date of "04/13/09" with the diagnoses including Dementia and Hypertension. The "Plan of Treatment" (the agency's Plan of Care) dated "04/13/09 - 10/13/09" documents orders for: "HHA/PCA" five (5) to seven (7) days, six (6) to eight (8) hours a day. There is no documentation to identify the specific level of paraprofessional services (hha or PCA) that the patient is receiving from the agency. During interview with the Director of Clinical Services (DCS) and Regional Area Manager on 7/09/09 at 2:15PM, the survey findings were reviewed for Patients #2, #3, #4, #6 and #11. The DCS stated that the nurses should be identifying the level of aide service whether it's a hha or PCA. The DCS further stated that the agency revised the Plan of Treatment forms back in March of this year to reflect "HHA/PCA".	H 404	**Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.** **Persons responsible for the corrections and ongoing compliance are:** **Field Nurse Supervisors** **Regional Office Administrator** **Director of Clinical Services** **VP of Operations** **Completion date: 9/30/09** Agreed to Ok 9/2/09 Amended x 11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	766.5(b)(3) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (3) clinical records are kept complete and changes in patient condition, adverse reactions, and problems with informal supports or home environment are charted promptly and reported to supervisory staff. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to maintain complete patient care records and ensure that the home health aide (hha) and the personal care aide (PCA) document according to the aide's "Plan of Care" (written instructions). This was evident in four (4) of eleven (11) patient care records reviewed. (Patients #1, #5, #8, and #9). Failure to ensure that the home health aides and personal care aides document the tasks performed according to written instructions places the patients at risk for poor patient outcomes. The findings are: 1) Patient #1 - admitted to the agency on "5/30/09" with diagnoses of CAD (Coronary Artery Disease) and Renal Failure. The Plan of Care signed by the physician on "6/11/09" documents orders for: "HHA/PCA" (home health aide/Personal Care Aide) "frequency: Days per week 5 to 7 Hours per day 4	H 618	**I. Corrective action for those patients found to be affected by the deficient practice:** **1. Office Administrator (OA) was counseled on 7/22/09 regarding appropriate branch oversight of patient records.** **2. Field Nurse Supervisors were counseled by Office Administrator on 7/22/09 regarding appropriate review of time sheets.** **3. Patient #1 was discharged on 7/17/09. HHA was reoriented regarding appropriate documentation on duty sheets to reflect plan of care.** **Patient #8 - HHA was reoriented regarding appropriate documentation on duty sheets to reflect plan of care** **Patient #5 - PCA was reoriented regarding appropriate documentation on duty sheets to reflect plan of care** **Patient #9 - HHA was reoriented regarding appropriate documentation on duty sheets to reflect plan of care.** **All counseling and re-orientation was completed by Office Administrator on 7/22/09.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients are affected by this regulation.** A Mendelkern	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 5 to 9 Hours and days may vary upon patient preference." The aide is to assist with ADLS (activities of daily living), and other duties as directed by the Plan of Care. The aide Plan of Care dated "5/30/09" documents instructions to "assist with personal care, prepare low salt meals as needed, encourage fluid intake ... and remind to take medication daily." The aide activity sheets dated "6/02/09, 6/03/09, 6/05/09, 6/08/09 - 6/10/09 and 6/12/09" lack documentation that the aide reminded the patient to take medications. On 7/10/09 at 9:00 AM, the Director of Clinical Services (DCS) and Regional Area Manager (RAM) were informed of the survey findings. The DCS and the RAM did not provide an explanation. 2) Patient #8 - admitted to the agency on "1/24/09" with diagnosis of Compression Fracture of Back. The aide Plan of Care dated "3/27/09" and updated on 5/27/09 documents instructions: "Personal Care, household tasks, prepare and serve low fat and low salt diet, and remind to take medication." The aide activity sheets dated 5/18/09 - 5/22/09 lacks documentation that the aide reminded the patient to take medications. On 7/10/09 at 9:00 AM, the agency's DCS and RAM were informed of the findings. The DCS stated that "the nurses do review the aide activity sheets." No further explanation was provided.	H 618	**The clinical record audit tool will be revised to reflect that the HHA/PCA duty sheets match HHA/PCA plan of care.** **The Branch Field Nurse Supervisors will audit 100% of the HHA duty sheets and compare them to the HHA plan of care for private pay and case managed cases and initial that they were reviewed.** **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **Field Nurse Supervisors will review HHA/PCA duty sheets against the HHA/PCA plan of care, circle discrepancies and notify the HHA/PCA of the discrepancies.** **The HHA/PCA was reoriented regarding accurate documentation on duty sheets to match the HHA/PCA plan of care and following the HHA/PCA plan of care.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **Agency auditors will be educated on the change in the audit tool.** **The Branch will audit 10 clinical records quarterly for the presence and accurate completion of the HHA/PCA duty sheets.** Amended X II	9/30/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 6 3) Patient #5 - admitted to the agency on "1/30/09" with diagnosis of Hypertension. The Plan of Care dated "01/30/09 - 07/30/09" documents orders for: "HHA" (home health aide) " frequency: Days per week three (3) to four (4) days three (3) to four (4) Hours a day. Aide to assist with ADLS, and personal care". The aide's Plan of Care dated "3/30/09 and 5/20/09" documents instructions to complete the task of "remind to take medication daily". The aide activity sheets dated "2/16/09 to 2/27/09, 3/23/09 to 4/24/09, 5/25/09 to 5/29/09 and 6/08/09 to 6/12/09" lacks documentation that the hha reminded the patient to take medications. On 7/09/09 at 2:15PM, the agency DCS and RAM were informed of the findings. The DCS stated that "the nurses do review the aide activity sheets." No further explanation was provided. 4) Patient #9 - admitted to the agency on "2/28/08" with diagnoses of Brain Tumor and Breast Cancer. The Plan of Care dated "2/28/09 - 8/28/09" documents orders for: "HHA" (home health aide) "frequency: Days per week five (5) to seven (7) days three, four (4) to eight (8) Hours a day. Aide to assist with ADLS, and personal care". The aide's Plan of Care dated "4/28/09 and 6/18//09" documents instructions to complete the tasks of "ROM (Range of Motion) exercises daily, remind patient to take medication daily and incontinence care every visit". The aide activity sheets dated "5/4/09 to 5/15/09,	H 618	**Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.** **Persons Responsible for the corrections and ongoing compliance are:** **Field Nurse Supervisors** **Regional Office Administrator** **Director of Clinical Services** **VP of Operations** **Completion date: 9/30/09** Accepted 9/2/09 Amended	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 7 5/24/09 to 5/28/09, 6/01/09 to 6/05/09 and 6/08/09 to 6/12/09" lack documentation that the hha performed the tasks of ROM exercises and incontinence care. The aide activity sheets dated "5/16/09 and 5/18/09 to 5/22/09" lacks documentation that the hha performed the task of incontinence care. The aide activity sheet dated "6/11/09" lacks documentation that the hha reminded patient to take medications. The aide activity sheet dated "6/07/09, 8 :00 AM to 12:00 PM four (4) hours" was found to be blank and was signed and dated "6/07/09" by the hha and the registered nurse. On 7/09/09 at 2:15PM, the agency DCS and RAM were informed of the findings. The DCS stated that "the nurses do review the aide activity sheets." No further explanation was provided.	H 618		
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Regulation is not met as evidenced by: Based on reviewed records and staff interview, the Governing Authority (GA) failed to ensure	H1002	Accepted Amended XT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From page 9 issue the certificate to the aide and the certificates are issued from the corporate office." The RAM further stated that "the agency will make all necessary changes to the Competency Evaluation Forms to reflect changes."	H1002	Resubmitted **H1008** **I. Corrective action for thuse patients found to be affected by the deficient practice:**	
H1008	766.9(d) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (d) adopt and approve amendments to written policies regarding the management and operation of the home care services agency and the provision of health care services. This Regulation is not met as evidenced by: Based on record review and staff interview, the Governing Authority failed to ensure that the policy and procedure was complete to include the required annual supervision of all agency staff that are responsible for the provision of patient health care services. Failure to ensure that the agency's policy and procedures are complete to ensure the safety of patient health care services, places the patients at risk for poor quality of care. The finding is: The agency policy and procedure for"... Clinical Supervision of Professional Staff" documents : "...Vice President of Clinical Services or Regional Director of Clinical Services is responsible for the supervision of all Field Nurse Supervisors...the Field RN (Registered Nurse) Supervisor is responsible for the supervision of all professional	H1008	**Agency policy and procedure was revised to reflect "Professional staff receives an evaluation after 90 – day probationary period and annually thereafter".** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients are affected by this regulation.** **100% of FNS Personnel Records will be audited to ensure compliance with the required probationary and annual evaluations.** **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **As per agency policy, the Office Administratur will ensure that all new hires will have an evaluation at the 90-day probationary period and then annually thereafter.** **In accordance with agency policy, all current staff will have annual evaluations completed by the Regional Director of Patient Services.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **Annual evaluations will be completed on all professional staff by the Regional Director of Patient Services.** **100% of applicable personnel records of professional staff will be audited by the Branch quarterly to ensure compliance with annual evaluations.**	7/22/09 9/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1008	Continued From page 10 staff.....7. Supervision should occur at frequent intervals during the probationary period in order to ensure safe patient care and staff familiarity with agency procedures....8. Ongoing supervisory activities may be adjusted by the Director of Clinical Services in order to meet the specific needs of staff members". There is no documentation in the agency's policy and procedure of the required annual supervision of all professional staff that are responsible for the delivery of patient care services. During interview on 7/09/09 at 2PM with the Regional Area Manager and the Regional Director of Clinical Services, the agency's staff did not provide an explanation for finding.	H1008	**Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Regional Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Admiuistrator and Director of Clinical Services, based on the findings will determine if the system is effective and make revisions as necessary.** **Persons responsible for the correction and on-going compliance are:** **Regional Office Administrator** **Director of Clinical Services** **VP of Operations** Area 9/2/09 **Completion date: 9/30/09**	
H1010	766.9(e) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (e) make available to the public information concerning the services which it offers, the geographic area in which these services are made available, the charges for the various types of service and the payment mechanisms which may be available for such services. This Regulation is not met as evidenced by: Based on observation ,record review, home visit (HV), and staff interview, the Governing Authority failed to ensure that the agency accurately advertise services which are approved by the New York State Department of Health (NYSDOH).	H1010	**I. Corrective action for those patients found to be affected by the deficient practice:** **1. The Office Administrator to reorient FNS's regarding services offered by agency and provision of appropriate documentation to patient.** **Patient #1 –FNS to review services provided by home health agency, cross out services not provided and have patient sign, place in clinical record.** 7/22/09 **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients are affected by this regulation.** **1. All case managed records will be audited to eusure only services provided by agency are identified.** 09/30/09 HM Supervisor II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1010	Continued From page 11 Advertising services which the agency is not licensed to provide has the potential for patients to receive agency services without Department of Health oversight. The findings include: The agency "Admission Package" that includes the "Consent for Treatment" documents: "physical therapists and/or other health professionals" as a service the agency is able to provide." The agency license observed posted on the wall documents Nursing, home health aide (hha) and Personal Care Aide (PCA) as the approved services and documents: "Nassau, Suffolk and Queens" counties as the agency's service area. During a home visit to Patient #1 on 7/09/09, the "Consent for Treatment" form in the "Admission Package" was reviewed and documents "physical therapist" and/or other health professionals". The agency is not authorized to provide Physical Therapy in the state of New York. During an interview with the Director of Clinical Services (DCS) and Regional Area Manager (RAM) on 7/09/09 at 10:30 AM, the RAM stated that "in the State of New York we do not provide Physical Therapist or any other services." The RAM confirmed that "the nurses should be crossing out when the case is opened."	H1010	**2. Results of audit will be reviewed with FNS. FNS will cross out services not provided, and have patient sign new consent on next visit. At the time of the visit, the FNS will explain services offered by the Hempstead Branch Office.** **3. All new admissions will be reviewed by the branch and ensure that physical therapy is crossed out and other services as well.** **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **Office Administrator will reorient FNS's regarding appropriate completion of the consent form. Cross out services not indicated or offered in the branch. (Consent form is utilized for all branches 32 in 7 states which are why physical therapy and other services are on there). The Branch will audit 10% of case managed records quarterly for accurate completion of the "Consent for Treatment" Form.**	
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in	H1036	Accepted AMended x II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1010	Continued From page 11 Advertising services which the agency is not licensed to provide has the potential for patients to receive agency services without Department of Health oversight. The findings include: The agency "Admission Package" that includes the "Consent for Treatment" documents: "physical therapists and/or other health professionals" as a service the agency is able to provide." The agency license observed posted on the wall documents Nursing, home health aide (hha) and Personal Care Aide (PCA) as the approved services and documents: "Nassau, Suffolk and Queens" counties as the agency's service area. During a home visit to Patient #1 on 7/09/09, the "Consent for Treatment" form in the "Admission Package" was reviewed and documents "physical therapist" and/or other health professionals". The agency is not authorized to provide Physical Therapy in the state of New York. During an interview with the Director of Clinical Services (DCS) and Regional Area Manager (RAM) on 7/09/09 at 10:30 AM, the RAM stated that "in the State of New York we do not provide Physical Therapist or any other services." The RAM confirmed that "the nurses should be crossing out when the case is opened."	H1010	Addendum # H1010 (continued). **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make revisions as necessary.** **Persons responsible for the correction and on-going compliance are:** **Field Nurse Supervisors** **Regional Office Administrator** **Director of Clinical Services** **VP of Operations** **Completion date: 9/30/09** Acceptable 9/2/09	
H1036	766.9(I) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in	H1036	Accepted Amended x II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1304 H1304	Continued From page 14 766.11(b) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (b) that qualifications for home health aide and personal care aide as specified in section 700.2 of this Title are met. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure the an employee has home health aide (hha)qualifications. This was evident for one (1) of one (1) Trainee (Nurses Aide Transitioning) record reviewed. (Employee #1/Trainee #1). Failure to ensure that all hha employees have their certificate from qualifying training programs prior to employment places the patients at risk for receiving poor quality care by unqualified staff. The finding is: The personnel record of Employee #1/Trainee #1 lacks documentation that the aide received the Home Health Aide Certificate of Completion. The employee was hired on "2/19/09" and serviced clients from 3/06/09 to the present. The employee/trainee record documents completion of "Nurses Aide Transitioning" on 4/30/09. During an interview with the Director of Clinical Services (DCS) and Regional Area Manager (RAM) on 7/10/09 at 9:35 AM, the RAM stated that "the agency had 90 days to issue the certificate and the certificates are issued from the corporate office". The RAM could not verify if the	H1304 H1304	**I. Corrective action for those patients found to be affected by the deficient practice:** **No specific patients were identified in the citation.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients are affected by this regulation.** **1. All active HHA/PCA employee records will be audited to ensure applicable certificate document is in the file. In the event that appropriate document is not located in the record, employee will be removed from the case until appropriate documentation is obtained.** **2. The branch will audit 10 personnel records per quarter for certificate completion.** **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **The Office Administrator/Compliance Coordinator will review all new hire personnel files to ensure all appropriate documentation is present.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee**	9/30/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1304	Continued From page 15 Trainee #1/Employee #1 had received the hha certificate. During telephone interview on 7/14/09 at 9:20AM with the RAM to clarify the Employee's "position title", the RAM faxed the requested information on 7/14/09 at 11:50AM. The fax documents that the Employee was hired as a "HHA (home health aide)". The agency's staff did not provide an explanation for the agency hiring the employee as a hha prior to the completion of the Nurses Aide Transition on 04/30/09.	H1304	**meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.** **Persons responsible for the correction and on-going compliance are:** **Regional Office Administrator** **Director of Clinical Services** **VP of Clinical Services** **Compliance Coordinator** **Completion date: 9/30/09**	
H1337	766.11(f)(ii) Personnel Section 766.11 Personnel The governing authority or operator shall ensure for all health care personnel: (f)(ii) a criminal history record check to the extent required by section 400.23 of this Title This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to complete the required supervision for the temporary employees awaiting the Criminal History Record Check (CHRC) report results. This was evident in three (3) of four (4) employees requiring CHRC supervision. (Employees #1, #3 and #8). Failure to supervise the temporary employees, places the patients at risk for poor quality care. The findings are:	H1337	**I. Corrective action for those patients found to be affected by the deficient practice:** **No specific patients were identified in the deficiency.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients are affected by this regulation.** **The compliance coordinator will run weekly reports from the Arrow system to determine HHA's/PCA's with outstanding CHRC's and the need for provisional visits.** **Timely initial supervision will be provided with an onsite visit followed by telephone supervision in alternating weeks.** Amended x II	9/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From page 16 1) Employee #1 was hired by the agency as a home health aide (hha) on "2/21/09" and was assigned to first case on "3/06/09". The personnel record documents alternate on-site/telephone supervision weekly until "5/01/09". The record lacks documentation of telephone supervision for the weeks of 5/09/09, 5/16/09 and the week of 6/27/09. On 7/10/09 at 11:30 AM, the findings and requirements for temporary supervision were reviewed with the agency's Director of Clinical Services (DCS) and Regional Area Manager (RAM). The RAM and/or DCS did not provide an explanation for the survey findings. 2) Employee #3 was hired by the agency as a PCA (personal care aide) on "2/17/09" and was assigned to the first patient on 3/09/09. The personnel record documents an alternate on-site/telephone supervision until 4/10/09. There is no documentation of on-site supervision for the weeks of 4/11/09 and 4/25/09. The next on-site supervision was conducted on "4/21/09". The personnel record lacks supervision after 6/22/09. On 7/10/09 at 11:30 AM, the findings and requirements for temporary supervision were reviewed with the agency's DCS and RAM. The RAM/DCS did not provide an explanation for the survey findings. 3) Employee # 8 was hired by the agency on "2/17/09" as a PCA and was assigned to the first patient on 3/16/09. The personnel record lacks documentation of the initial onsite supervision by the registered and/or	H1337	**III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **Field Nurse Supervisors, coordinator and compliance coordinator were in-serviced on 7/22/09 regarding the CHRC policy and procedure, supervision of HHA's/PCA's and schedule for provisional visits.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **The compliance coordinator will review the logs in the Arrow System weekly to ensure scheduled compliance activities. The Office Administrator will monitor this process.** **The Branch will audit 10 records quarterly to ensure to ensure compliance with CHRC and provisional visits.** **Based on the structure established by the governing authority, Audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Regional Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.** Amended x II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1337	Continued From page 17 licensed nurse. The personnel record documents that the onsite/offsite supervision was performed every two (2) weeks and not the required alternating weekly onsite/offsite supervision. There is no documentation of on-site supervision for the weeks of 3/23 /09, 4/14/09 and 5/25/09. The personnel record lacks supervision after 6/29/09. There is no off-site supervision performed on the weeks of 4/07/09, 4/21/09, 5/04/09, 5/18/09 and 6/21/09. During interview on 7/10/09 at 1:15PM, the findings and requirements for temporary supervision were reviewed with the agency's DCS and RAM. The RAM stated that the "CHRC report results have not been received yet by the agency". The RAM/DCS did not provide an explanation for the survey findings. The agency Policy and Procedure for "9.20 Criminal Background Checks (CHRC) - Fingerprinting" documents the procedure for supervision as: "..... All newly hired fingerprinted employees will be supervised in accordance with the Department of Health regulations. Supervision must start with a field visit by an RN or LPN (Registered Nurse/Licensed Practical Nurse). The following week's supervision will be conducted by telephone. Employees will then be supervised through field visits and telephone calls on alternate weeks...."	H1337	**Persons responsible for the correction and on-going compliance are:** **Regional Office Administrator** **Field Nurse Supervisors** **Coordinator** **Compliance Coordinator** **Regional Director of Clinical Services** **VP of Clinical Operations** **Completion date: 9/30/09** * Not receipt of [illegible] did not include copy of three reports for noted employee in SOC - 9/2/09 9/3/09 9am - f/c to Bonnie Duggan - DCS re: not obtaining required three (3) agency updates - due three employee no longer employed - was computer generated - system problem [illegible] Amended x II	
H1454	766.12(c) Records and reports 766.12 Records and reports.	H1454		

Lopez Greg 1 yr hrs - Monica Lopez - office staff unverified
B Lopez 3 1 no record - lacking two other years
Agency to fax 6 yrs + clearance sign to NYS DOH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1454	Continued From page 18 (c) The home care services agency shall furnish annually to the department a copy of: (1) statistical summaries of all health care services delivered on forms provided by the department; (2) if a for-profit corporation, a list of the principal stockholders and the number and percent of the total issued and outstanding shares of the corporation held by each, duly certified by the secretary of the corporation as to completeness and accuracy; (3) if a not-for-profit corporation, a list of directors, officers and corporate members, if such members number 10 or fewer; and (4) other such records and reports as may be legally required by the department. (d) The agency shall furnish simultaneously to the department copies of all notices and documents required to be filed with the Securities and Exchange Commission. This Regulation is not met as evidenced by: Based on interview, the agency failed to provide the required statistical reports for the survey. Failure to ensure that the agency has submitted the required annual statistical reports to the New York State Department of Health (NYSDOH) places the patients at risk for poor quality of care. The finding is: On 7/9/09, the agency's annual statistical reports for the years 2006 and 2007 were requested. The requested reports were not provided by the home	H1454	**I. Corrective action for those patients found to be affected by the deficient practice:** **No specific patients were identified in the deficiency.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **This regulation would not affect patient outcomes.** **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **2006 and 2007 statistical reports will be resubmitted.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **1. A process has been put in place for the Information Technology and Operations Departments to complete process on a timely basis.** **2. Statistical reports will be completed and submitted annually.** **This will be monitored by the governing body annually.** **Persons responsible for the correction and on-going compliance are:** **Chief Operating Officer** **Chief Financial Officer** **VP of Information Technology** **Completion date: 9/30/09**	9/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC3536C	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	50 CLINTON STREET STE 608 HEMPSTEAD, NY 11550

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1454	Continued From page 19 care agency. During interview on 7/09/09 at 2:00PM with the Regional Area Manager (RAM), the RAM stated that "the agency's corporate office is responsible to submit the reports". The agency was provided time to locate/provide the required reports. During interview on 7/10/09 at 11:30AM with the agency's RAM, the RAM stated that "the corporate office is still looking for them".	H1454	Amended KTT	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0411D	A. BUILDING _____ B. WING _____	C 09/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - BABYLON	181 WEST MAIN STREET BABYLON, NY 11702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments Surveyor: 10733 A Complaint Survey was conducted on September 30, 2009. Complaint # NY00077121 Three (3) patient care records were reviewed and identified as Patients #1 - #3. One (1) personnel record was reviewed and identified as Employee #1.	H 000		
H 614	766.5(b)(1) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised The department shall consider the following factors as evidence of adequate supervision: (1) staff regularly provide services at the times and frequencies specified in the patient's plan of care and in accordance with the policies and procedures of their respective services. This Regulation is not met as evidenced by: Surveyor: 10733 Based on record reviews and staff interview, the agency failed to ensure that the patient received the the Personal Care Aide (PCA) services as ordered on the Plan of Care in three (3) of three (3) three patient care records reviewed. (Patients #1, #2, and #3) Failure to provide PCA services as ordered places all patients at risk for not having their needs met and substandard care. The findings are:	H 614		TN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Vicki Reilly TITLE VP of Home Health Services (X6) DATE 11-5-09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0411D	A. BUILDING _____ B. WING _____	C 09/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - BABYLON	181 WEST MAIN STREET BABYLON, NY 11702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 614	Continued From page 1 1) Patient #1 has an admission date of 4/28/09 with the diagnosis of Dementia. The Suffolk County Department of Social Services (SCDSS) Shared Aide Care Plan dated 8/28/09 documents an increase of PCA hours to "23 hours a week". The plan includes "PCA to arrive at 6:30 am and 3:30 pm". The agency's "Client Schedule Report" lacks documentation that the patient received the PCA service in the morning. During interview with the Coordinator on the case on 9/30/09, the Coordinator stated that the agency has "not been able to staff" the morning hours. 2) Patient #2 has an admission date of 11/21/06 with diagnoses which include Hypertension, Bursitis and Hard of Hearing. The SCDSS Shared Aide Care Plan dated 3/27/09 documents orders for 20 hours of PCA service a week. The plan includes "PCA to leave when a.m. tasks complete". The patient attends Day Care. The "Client Schedule Report" lacks documentation that the patient received the PCA service in the morning from 7/30/09 - 9/02/09. The "Client Notes Print" dated 8/04/09 and 8/05/09 documents that the patient was "waiting for a specific PCA to provide care" and that the patient would"receive a shower at Day Care". During interview with the Coordinator on 9/30/09, the Coordinator stated that the agency did not	H 614	**H 614 CLINICAL SUPERVISION** It is the policy of All Metro Health Care that all patients be provided services according to the Physician's Plan of Care or the Prior Approval, for DSS cases. If there is a change in the Plan of Care/Prior Approval, the schedule change is to be made in the Scheduling System as soon as we are made aware. If All Metro is unable to staff the case as requested, the entity ordering/approving the services is to be notified immediately so that the referral source has the opportunity to approach another agency regarding the unfilled hours. The staff shall make an earnest effort to rearrange schedules and fill hours until the case can either be permanently restaffed or referred elsewhere. It is further our policy that such communications with a family member or referral source be documented in the chart or the ProHealth system for the edification of other associates working on the case. The current caseload has been reviewed for recurring open hours and referral sources were contacted while restaffing efforts were made and two of three cases noted in the SOC were covered fully. The third consistently refuses every employee we send, yet refuses referral to another agency. A transfer was arranged and the patient's dtr. refused to leave AMHC, although we have ongoing difficulties covering the case. DSS will be contacted for additional guidance in transferring the case to an agency who can cover it to the satisfaction of the patient's dtr.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0411D	A. BUILDING _____ B. WING _____	C 09/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - BABYLON	181 WEST MAIN STREET BABYLON, NY 11702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 614	Continued From page 2 notify SCDSS that they were not providing the PCA service as ordered. 3) Patient #3 has an admission date of 11/19/07 with diagnoses of Hypertension, Congestive heart Failure, and Anemia. The SCDSS Shared Aide Care Plan dated 12/05/08 documents 33 hours of PCA services with tasks assigned seven (7) days a week. The "Client Schedule Report" lacks documentation that the patient received service on Sundays from 6/29/09 - 9/20/09. The "Client Schedule Report" dated 5/04/09 documents a conversation with the patient's son "....NSN (no service needed) on Sunday's anymore". During Interview with the Coordinator on 9/30/09, the Coordinator did not provide documentation that SCDSS was notified of the change in frequency of PCA service as ordered.	H 614	All associates and On-Call staff will be reoriented to All Metro's policy regarding open hours and necessary communication to minimize the likelihood of patients being placed at risk. The open hours report will be reviewed by the DCS/Br. Mgr. weekly at the weekly staff meeting, along with the associated patient notes to assure proper documentation and communication. Repeated lapses in documentation will be treated as a disciplinary matter with personnel replacement if necessary. Responsible Individual – Branch Manager and Director of Clinical Services Completion Date – 11-30-09 T/C 11/6/09 @ 10:45 AM to Sr. VP of Pt Svc. Target for monitoring is 90% – action stated above. Accepted 11/6/09 TN	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Re-Licensure and Complaint Investigation (NY00077942 and NY00077870) survey was conducted at Caring Hands Home Care, Inc. on 11/03/09. One (1) Patient care record was reviewed and identified as Patient #1. One (1) home visit was made to Patient #1. Eight (8) personnel records were reviewed and identified as Employees #1 - #8.	H 000	766.1(a)(1) H204 A) The director of nursing shall be the designated individual responsible for correction of H204 B) Corrective action taken is a new admission package to be signed by current patient. In-service provided to the nursing supervisor C) Current admission package to be reviewed at QA meeting scheduled for 12/15/09.The admission package is to be included in the chart audit tool. To prevent recurrence of this issue charts will be audited monthly times 2 till 100% compliance is met. D) Following chart audit a written report will be generated by the QI. Staff findings will be reviewed at the quarterly QIC meeting/ ongoing in-service to continue. The GA / operator are to include this deficiency on its calendar and tickler system. Ongoing in-services to be provided as needed. Accepted 12/7/09 SR	
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges; (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient. (i) The agency shall advise the patient of any	H 204		12/15/09 (IBD)

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 1 changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to provide a complete Admission Package as requested for review. This was evident for the agency Admission Package. Failure to have a complete Admission Package places patients at risk for not being able to exercise their rights. The findings are: During an entrance conference, the Owner was given a list of items needed to conduct a Re-Licensure and Complaints survey. One of the items requested was the agency's Admission Package. Throughout the survey, multiple requests were made to provide the agency's Admission package. At 2:00 PM, the Owner provided copy of the "Patient Rights and Responsibilities", "Emergency Telephone Numbers"and a "Referral Forms" for review. During an interview on 11/03/09, the Owner was	H 204		

Bright Durken 12/4/09
owner

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 2 informed that this is not the complete Admission Package. The Owner stated: "I guess, then I don't have an Admission Package right now".	H 204		
H 618	766.5(b)(3) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (3) clinical records are kept complete and changes in patient condition, adverse reactions, and problems with informal supports or home environment are charted promptly and reported to supervisory staff. This Regulation is not met as evidenced by: Based on record review and staff interview, the Governing Authority (GA) failed to ensure that the home care agency provides supervision to the staff delivering patient care. The agency Registered Nurse (RN) and the Physical Therapist (PT) failed to notify the supervisory staff and/or the physician regarding changes in the patient's clinical status. This was evident in one (1) of one (1) patient care record reviewed (Patient #1). Failure to ensure that the RN and the PT are supervised and notify the supervisory staff and/or physician regarding changes in the patient's clinical status places the patient at risk for poor quality of care and the potential for negative patient outcome. The findings are:	H 618	SEE pg 6 12/15/09 Bright Austin 12/4/09 Owner	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 3 Patient #1 has re-admission date of 4/28/06 with the diagnoses including Acute Encephalomyelitis, Quadriplegia and Tracheostomy with Ventilator Dependence. The Plan of Care dated 4/28/09 to 10/28/09 documents the orders for "Skilled RN 7 (seven) D (days) x 24H (twenty four hours) ongoing respiratory and neurological assessment with skilled intervention when needed. VS (vital signs) BID (twice a day)" and "PT 3 (three) times a week" for "PROM (passive range of motion) via PT only". The Plan of Care documents orders for the medications: "Diovan 80mg /HCTZ 12.5mg PO (by mouth) qam (every morning) Hold for SBP (Systolic Blood Pressure) < (less than) 120 & DBP (Diastolic Blood Pressure) <90. Divan 80mg PO every PM (evening) Hold for SBP < 120 & DBP <90". The Plan of Care does not include orders that would require physician notification for elevation in patient's vital signs, such as BP(blood pressure) and HR (heart rate) parameters. The Skilled RN and the PT patient care visit notes document observed elevation in the patient's vital signs, such as BP and HR on multiple days. The patient care record lacks documentation that the Skilled RN and the PT had informed/notified the supervisory staff and/or physician regarding the changes in the patient's clinical status. The Skilled RN visit notes documents the following:	H 618	Bright Rank 12/4/09 Owner	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 4 On 9/15/09 (4:00 PM to 12:00 AM) BP was noted as "135/90, HR 104". Vital signs were not repeated during the shift. On 9/23/09 (12:00 AM to 8:00 AM) BP was noted as "129/99". There is no documentation of the BP being repeated during the shift. On 10/01/09 (7:00 AM to 3:00 PM), and 10/03/09 (4:00 PM to 1:00 AM). There were no vital signs documented. On 10/12/09 (12:00 AM to 8:00 AM), the BP is documented as "155/93", and (8:00 AM to 4:00 PM) BP was noted as "85/55". On 10/15/09 (7:00 AM to 3:00 PM) the BP is documented as: "141/101". There is no documentation of the BP being repeated during the shift. On 10/17/09 (8:00 AM to 12:00 AM) the BP is documented as: "141/102". There is no documentation of the BP being repeated during the shift. The PT visit notes documents the following: On 6/09/09 - the pre treatment BP is documented as "151/105" and post treatment BP "133/91". On 6/18/09 - the pre treatment BP is documented as: "143/96" and post treatment BP "135/93". On 6/20/09 - the pre treatment BP is documented as: "136/95, HR 112" and post treatment BP "109/74, HR 107". The agency policy and procedure for "Clinical Supervision" lacks documentation of the date the	H 618	Brigit Durkin 12/4/09 Owner	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

to include the above deficiency on its calendar and in its tickler system. Organizational restructuring to take place over the next month involving upper management.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 5 GA approved the policy and procedure. The "Clinical Supervision" policy and procedure documents the following under the heading Procedure documents: IV. "All staff delivering care in patient homes is adequately supervised... C. Clinical records are kept complete and changes in patient condition, adverse reactions and problems with informal supports or home environment are charted promptly and reported to the supervisory staff. D. Plans of Care are revised as needed by the patient and changes are reported to the patient's physician and other staff providing care to the patient. E. All nursing personnel must notify Caring Hands immediately with any changes in patient's condition. Nursing Supervisor will address supervision accordingly. Changes in the plan of care must be made to the authorized practitioner and other agencies which authorize payment for services, as appropriate and necessary." During an interview with the agency Owner on 11/03/09, the Owner did not provide additional documentation and/or an explanation for the findings.	H 618	766.5 (B)(3) Clinical Supervision H618A) The nursing supervisor on each case shall be the responsible designer of each case responsible for correction. B) The current nursing supervisor and one other RN on each case has been oriented to their responsibility on their case. Weekly written nursing supervisory reports to be submitted to the director of nursing. They are to include VS review for the week. Nursing Supervisor to obtain MD orders for correct VS parameters for notification to MD. Each nurse and therapist to be in-serviced at home on correction by 12/15/09 C) To prevent the reoccurrence of this issue all charts will be audited monthly times 2 till 100% compliance is met. Starting 1/10/10. Quarterly audits will be preformed to ensure compliance. D) The QI staff will develop a VS audit tool to be included in chart review based on revised P&P clinical supervision. Staff will perform audit based on an established calendar by the director of nursing. The QI staff will generate following chart audit a written report. Findings will be presented for discussion during the quarterly QIC meeting ongoing in-services to continue as needed. The GA/operator	12/15/09
H 714	766.6(a)(6) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include:	H 714		

Bright Kunder owner 12/11/09 BP

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 618	Continued From page 5 GA approved the policy and procedure. The "Clinical Supervision" policy and procedure documents the following under the heading Procedure documents: IV. "All staff delivering care in patient homes is adequately supervised... C. Clinical records are kept complete and changes in patient condition, adverse reactions and problems with informal supports or home environment are charted promptly and reported to the supervisory staff. D. Plans of Care are revised as needed by the patient and changes are reported to the patient's physician and other staff providing care to the patient. E. All nursing personnel must notify Caring Hands immediately with any changes in patient's condition. Nursing Supervisor will address supervision accordingly. Changes in the plan of care must be made to the authorized practitioner and other agencies which authorize payment for services, as appropriate and necessary." During an interview with the agency Owner on 11/03/09, the Owner did not provide additional documentation and/or an explanation for the findings.	H 618	to include the above deficiency on its calendar and in its tickler system. Organizational restructuring to take place over the next month involving upper management. Accepted 12/7/09 SR Bright Dunlin 12/4/09 Owner	12/15/09 BD
H 714	766.6(a)(6) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include:	H 714		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	LC0921A	A. BUILOING _____ B. WING _____	11/03/2009

NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From page 6 (6) supervisory reports of the registered professional nurse, licensed practical nurse or the therapist, if applicable, of the home health aide or personal care aide. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the patient care record is complete and includes documentation of the Physical Therapy (PT) home visits as ordered in the Plan of Care. This was evident in one (1) of one (1) patient record reviewed (Patient #1). Failure to ensure that the patient's record is complete places the patient at risk for unmet needs and poor quality of care. The finding are: Patient #1 has a re-admission date of 4/28/06 with the diagnoses including Acute Encephalomyelitis, Quadriplegia and Tracheostomy with Ventilator Dependence. The Plan of Care dated 4/28/09 to 10/28/09 documents an order for: "PT 3 (three) times a week" for "PROM (passive range of motion) via PT only". The patient care record lacks documentation of the PT visit notes for July, August, September and October 2009. During an interview on 11/03/09 with the Owner, the Owner provided the PT visit notes from January 2, 2009 - June 29, 2009. During the survey, the Owner stated that "the PT must have the visit notes for July, August,	H 714	H714 Patient care records A) All pt notes for July August and September have been obtained and reviewed by the director of nursing. The director of nursing conducted in-service training with the current pt on the importance of timely submission of pt notes and review of current parameters of BP. She has signed an affidavit of the above a post training review will be administered 12/10/09 to ensure learning has occurred. B) To prevent reoccurrence of this deficiency monthly chart audits will be preformed times 2 till 100% compliance is met. Starting 1/10/10. PT notes reviewed to be included in chart audit tool. The director of nursing will inform staff in writing regarding the auditing process prior to commencement. D) QI auditor will generate timely report and present findings for discussion at the emergency QI meeting on 12/15/09 and at the quarterly QIC meetings. Ongoing in-services to continue. GA to include the above deficiency on its calendar and in its Tickler system. Upper management restructuring to occur over the next month 12/15/09 (BP)	

Bright Kinkus
amen 12/4/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPUER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From page 7 September and October 2009 on her computer". The Owner further stated that the agency's policy for visit note submission is one (1) month. The Owner did not provide additional documentation to explain the incomplete patient care record. H1002 766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Regulation is not met as evidenced by: Based on patient record review, home visit, policy and procedures review, personnel record review and staff interview, the Governing Authority (GA) failed to ensure compliance with all applicable Federal, State, and local statutes, rules and regulations. Failure to ensure compliance with all rules and regulations, and to ensure the provision of responsible operation and management of the home care agency places all patients at risk for poor quality of care. This was evident in the following deficiencies: 766.1 Patient Rights 766.5 Clinical Supervision 766.6 Patient Care Record 766.9 Governing Authority	H 714 H1002	H1002 766.9 (A) Governing Authority The agencies governing body/operator has implemented the following agency changes to improve management and operation; ensuring safe patient care, striving to meet DOH regulatory body standards by employing a quality improvement consultant as of 12/15/09, reorganizing the quality Improvement Committee and providing appropriate staff in-service, which will be ongoing. In addition the following issues have been addressed accordingly: Patient rights (766.1), Clinical Supervision (766.5), Patient Care Records (766.6), Governing Authority (766.9), Personnel (766.11) and Records and Reports (766.12) B) In order to prevent re-occurrence of above mentioned issues and other similar issues the agency's governing body/operator has developed a system to oversee individual and committee activities on an on-going basis. C) A new quality Improvement Plan has been created; audit tools have been and will be created on an on-going basis; a revised reporting/filing system has been implemented; the QIC meeting agenda now includes standing time Bright Durkin 12/4/09 Owner	1/30/10

New York State Department of Health

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) .PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIOER OR SUPPLIER	STREET ADORESS. CITY. STATE. ZIP COOE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From page 7 September and October 2009 on her computer". The Owner further stated that the agency's policy for visit note submission is one (1) month. The Owner did not provide additional documentation to explain the incomplete patient care record.	H 714		
H1002	766.9(a) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (a) be responsible for the management and operation of the agency; (b) ensure compliance of the home care services agency with all applicable Federal, State and local statutes, rules and regulations. This Regulation is not met as evidenced by: Based on patient record review, home visit, policy and procedures review, personnel record review and staff interview, the Governing Authority (GA) failed to ensure compliance with all applicable Federal, State, and local statutes, rules and regulations. Failure to ensure compliance with all rules and regulations, and to ensure the provision of responsible operation and management of the home care agency places all patients at risk for poor quality of care. This was evident in the following deficiencies: 766.1 Patient Rights 766.5 Clinical Supervision 766.6 Patient Care Record 766.9 Governing Authority	H1002	allotments for the following areas: medical orders, clinical supervision, patient care, record reviews, personal reviews and an annual statistical summary reporting and filing will be preformed according to an established calendar (the HPN will be accessed on a daily basis) D) The agency's governing body/operator will utilize a reporting calendar to see that all areas of concern are addressed in a timely manner by the appointed personnel and take immediate action if/when there is variance.GA to include the above deficiency on its calendar and in its Tickler system. Upper management restructuring to occur over the next month. Bright Horizon 12/4/09 Owner 1/30/10 130	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From page 8 766.11 Personnel 766.12 Records and Reports	H1002		
H1006	766.9(c) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan. This Regulation is not met as evidenced by: Based on record review of the agency's emergency plan, policy and procedure and staff interview, the Governing Authority (GA) failed to develop a complete emergency plan. Failure to develop a complete emergency plan places all patients at risk for not having their needs met in an emergent situation. The findings are: The agency "Emergency Management and Disaster Preparedness Plan" (Policy VII-18) lacks documented evidence of a call down list of agency staff, a contact list of community partners, collaboration with community partners in planning efforts and participation in disaster drills and exercises. The emergency plan lacks policies and procedures addressing the procedure for	H1006	H1006 766.9(C) Governing authority "Emergency management and disaster plan isn't complete" "No revisions of P&P manual" "Criminal History Record Check lacks info" A) The agency's governing body/operator is the designated body to ensure continued compliance to deficiency H1006 B) The following corrective action has been taken; The nursing supervisor on the audit case has been assigned to review the individual emergency plan for the audit patient. A date of 12/14/09 has been given and the plan is to be submitted to the emergency QIC meeting on 12/15/09. The director of nursing has been assigned the task of implementing and updating the "Emergency Management and Disaster Plan" to include a call down list contact with community partners and participating in a disaster drill n exercises. Disaster drill to take place December 20 2009.The month of January has been marked on the QI calendar for an entire P&P review. The QIC Committee has been notified and have agreed to attend. Inservices to CHHC employees to occur after Jan.31, 2010.Ongoing in-services as needed. C) To prevent re-occurrence of issue/ the emergency preparedness plan of the agency is to be reviewed quarterly at the QIC committee meeting. Quarterly	1/30/10 KD

Bright Dexter 12/4/09 / answer

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1002	Continued From page 8 766.11 Personnel 766.12 Records and Reports	H1002		
H1006	766.9(c) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan. This Regulation is not met as evidenced by: Based on record review of the agency's emergency plan, policy and procedure and staff interview, the Governing Authority (GA) failed to develop a complete emergency plan. Failure to develop a complete emergency plan places all patients at risk for not having their needs met in an emergent situation. The findings are: The agency "Emergency Management and Disaster Preparedness Plan" (Policy VII-18) lacks documented evidence of a call down list of agency staff, a contact list of community partners, collaboration with community partners in planning efforts and participation in disaster drills and exercises. The emergency plan lacks policies and procedures addressing the procedure for	H1006	written report is to be submitted to the GA review quarterly D) Auditor will generate timely reports and present findings for discussion in the quality improvement meeting. On going in-services to continue.GA to include the above deficiency on its calendar and in its Tickler system. 1/30/10 KP	

Bright Durken 12/4/09
owner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1006	Continued From page 9 maintaining the agency's call-down list and the procedure for the agency to respond to requests for information by community partners in an emergency, annual review and update of plan and orientation of staff. During interview with the agency's Owner on 11/03/09, the Owner did not provide an explanation for the incomplete emergency plan.	H1006	H1008 Governing authority A) the governing body operator of the agency is to develop a new policy for criminal history checks. This is to include supervision of temporary staff and the scanning of finger printing cards. B) To prevent reoccurrence of this issue the CHRC policy is to be completed and reviewed at the January 22 QIC committee meeting. C) The agency's quality improvement staff will develop an audit tool to include Policy and procedure review. The review process will be ongoing D) The QIC committee to submit its quarterly report to the governing authority for review and acceptance to prevent a repeat deficiency again all information to be reviewed by the newly appointed QIC Czar for acceptance by 1/22/10.Ongoing in-services to continue. A to include the above deficiency on its calendar and in its Tickler system. Physician appointed on the QIC to review this policy individually for suggestions.	1/30/10 BP
H1008	766.9(d) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (d) adopt and approve amendments to written policies regarding the management and operation of the home care services agency and the provision of health care services. This Regulation is not met as evidenced by: Based on record review and staff interview, the Governing Authority (GA) failed to maintain written policies and procedures which are current and complete. This was evident for the agency policy and procedure manual. Failure to maintain current and complete policies and procedures places the patients at risk for poor quality of care. The findings are: 1) The agency policy and procedure manual lacks documentation of review and revision since the year 2007. 2) The policy and procedure for Criminal History	H1008		

Bright Durkin RN
owner 12/4/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1008	Continued From page 10 Record Check (CHRC) lacks documentation that the policy was reviewed to include the changes in the policy regarding the supervision of the temporary staff, and the scanning of finger printing cards. During an interview with the agency's Owner on 11/03/09, the Owner did not provide an explanation for the policies not being reviewed and incomplete. REPEAT DEFICIENCY FROM 7/17/2007 SURVEY	H1008	H1014 766.9(G) Governing Authority A) The agency's governing authority/operator has initiated contact with a local agency for a contract for ancillary services. HHA,ST,OT and MSW B) To prevent re-occurrence of this issue the QIC committee meeting is to include review of contracts in the agencies QIC quarterly meeting C) The agency's quality improvement staff will develop an audit tool based on the need of this repeated DOH deficiency. A designated QIC member will perform audits. The designated member will notify is writing to the GA/operator for the review. D) The corrective action to ensure this repeat practice will not occur again is the findings are to be reviewed monthly times 2 till 100% compliance is met. By the newly appointed QI/Czar. The agency's governing body/operator will utilize a reporting calendar to see that all areas of concern have been addressed and take immediate action if deemed necessary Accepted 12/7 109 SR Bright Darkin 12/4/09 Owner	12/30/09 BP
H1014	766.9(g) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (g) employ or contract for a sufficient number of staff to coordinate, direct and deliver services to patients accepted for care in accordance with prevailing standards of professional practice. This Regulation is not met as evidenced by: Based on record review and staff interview, the Governing Authority (GA) failed to employ or contract staff to provide the services identified on the agency's license. This was evident for personnel files/contracts for Speech Language Pathology (SLP), Occupational Therapy (OT), Medical Social Work (MSW), and Home Health Aide (hha) services. Failure to employ or contract staff to provide SLP, OT, MSW, and hha services places patients at risk for not having their care needs met.	H1014		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1014	Continued From page 11 The finding are: The personnel records and/or contract for the SLP, OT, MSW and hha services identified on the agency's license were requested. The agency's Owner did not provide the information requested. During interview with the agency's Owner on 11/03/09, the Owner stated that she "does not have" a personnel files or contracts for these services at this time. REPEAT DEFICIENCY FROM 7/17/2007 SURVEY	H1014	H1036 766.9 (I) Governing authority A) The agencies governing body/operator has implemented the following agency changes to improve management and operation insuring safe patient care, striving to meet DOH/ regulatory body standards by employing a QI Czar Catherine McLaughlin RN. . A QI czar has been immediately retained and all current deficiencies have been reviewed with her. She has agreed to an emergency meeting on 12/15/09. Monthly review of required records will be done times 2 till 100% compliance is met. . Also will initiate QIC meetings quarterly.A physician has been retained for the QIC Committee.He as agreed to met Quarterle and to be available for consulting when necessary.Dr.Brent Spers/107 berkshire Dr. Farmingville NY 11738/Tel 631-928-5800/Lic#147779. B) In order to prevent reoccurrence of the repeat deficiency H1036 the QI plan created and overseen by the newly appointed QI czar. She will oversee individual and committee activity on an ongoing basis C) The tools used are to be a revised reporting system for the QIC including monthly record audits for 100% compliance Meeting agenda will now include a physician and consumer. The operator of the agency is now	1/15/10 BR SR
H1036	766.9(I) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (I) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:	H1036		

Bright Durkin 12/4/09

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 12 (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section;. (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record review and interview, the Governing Authority (GA) failed to ensure that the Quality Improvement (QI) committee met four times a year; includes a physician and a consumer and patient care records/ policies/procedures are reviewed. This was evident for the Quality Improvement (QI) meeting minutes. Failure of the quality improvement committee to establish and oversee standards of care places patients at risk for receiving poor quality care. The findings are: 1) The QI meeting minutes from the year 2008 - present were requested during the entrance conference. The Owner provided one (1) meeting dated "February 5, 2009". There is no documented evidence of QI meetings conducted in the year 2008.	H1036	actively pursuing a consumer advocate. D) The QI above corrective action will be now Be overseen by the newly appointed QI czar Catherine McLaughlin RN. The agency's governing body/operator will utilize the reporting calendar to see that this deficient practice does not happen again. This Deficent practice will be included in the GA Tickler system. Unacceptable	1/15/10

Brigit Rusker 12/4/09
Laurie

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 13 2) The QI meeting minutes dated 2/05/09 does not include documented evidence of physician and consumer attendance. 3) There is no documented evidence that the agency reviewed policies and procedures pertaining to the delivery of the health care services provided by the agency. The QI meeting minutes lack documentation that the agency conducted a clinical record review of the active patient, and any discharged patients in the past three (3) months. During an interview with the agency's Owner on 11/03/09, the Owner stated that agency "had not conducted" any meetings in 2008. The Owner stated that she "does not currently" have a physician and consumer for quarterly meeting minutes. REPEAT DEFICIENCY FROM 7/17/2007 SURVEY	H1036		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of	H1142		

Bright Rankin 12/4/09
Owner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 14 operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to develop complete policy and procedures and maintain a complete Communication Directory. This was evident for the agency's "Emergency Management and Disaster Preparedness Plan" and Health Provider Network (HPN) account. Failure to develop complete policy and procedures and maintain a complete Communication Directory places the agency for not receiving information from the Department of Health necessary for the operation of the agency.	H1142	H1142 776.9 (O) "HPN" A) The governing body/operator will be the responsible designee for the HPN activities and occurrences till a HPN coordinator is retained by the 12/15/09 QIC meeting B) To prevent occurrences of the governing body/operator of the agency to review and plan HPN training of a new coordinator and QI in-services regarding HPN maintenance. To highly address this repeat deficiency from 7/17/07 a HPN coordinator must be trained promptly and issue a specific period for regulatory body updates and discussions will be included in the QIC meeting starting 12/15/09. In-service of the designated to access the HPN system to be ongoing). The Governing body/operator will present pertinent data regarding HPN and other regulatory body information in the QIC meeting. D) The governing body/operator will perform monthly review times 2 till 100% compliance is acheieved.of HPN compliance and other regulatory body information accordingly. Ongoing in-services to continue. The GA to include the above deficiency on its calendar and in its Tickler system.	1/30/10

Brigit Rucker 12/4/09
admin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 15 The findings are: 1)The agency policy and procedure for "Emergency Management and Disaster Preparedness Plan" includes the title of the hand written one word "HPN" on the same policy and procedure. The policy includes two (2) statements regarding the HPN. The statements are: 1) "B. Emergency and Disaster Preparedness", documents that the agency will "Participation in the NYS DOH HPN System" and 2) the "Owner", "RN is the designated person for maintenance of the HPN account. In her absence the designated person will be" ... "RN/VP of Operation". 2) The agency Communication Directory lacks documentation of the agency's 24 by 7 Contact; the Office the Administrator; the Director of Patient Services; the Governing Body President and members; HPN Coordinator; Criminal History Record Check Authorized Person; Emergency Response Coordinator and all positions identified for the Home Care Registry. 3) The "Contact Information for Caring Hands Home Care, Inc." on the HPN documents an incorrect telephone for the agency. The documented number: "631-218-8761" is not in service. During an interview with the agency's Owner on 11/03/09, the Owner stated that the correct number for agency is "631 736-3073". The Owner provided no explanation for the incomplete Communication Directory and incorrect agency number documented on the	H1142	unacceptable Brigit Durkin 12/4/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 16 HPN. REPEAT DEFICIENCY FROM 7/17/2007 SURVEY	H1142		
H1330	766.11(d)(4) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact: (4) ppd (Mantoux) skin test for tuberculosis prior to assuming patient care duties and no less than every year thereafter for negative findings.Positive findings shall require appropriate clinical follow up but no repeat skin test.The agency shall develop and implement policies regarding follow up of positive test results. This Regulation is not met as evidenced by: Based on record review and staff interview, the Governing Authority (GA) failed to ensure that all personnel have annual PPD/Mantoux skin tests for Tuberculosis. This was evident in four (4) of eight (8) personnel records reviewed (Employees #5, #6, #7 and #8). Failure to ensure that all personnel have the required annual PPD (Mantoux) skin test, places the patients at risk for possible exposure to communicable disease. The findings are: 1) Employee #8 Registered Nurse (RN) has a	H1330	H1330 766.11 (D) (4) personnel A) The director of nursing should ensure that all PPD's are current on all personnel B) The director of nursing has obtained all up to date PPD's on all current employees. Available to the DOH upon request. C) The QI Czar to monitor staff files monthly times 2 till 100% compliance is met. Starting 12/10/09. Then quarterly there after. The Director of nursing will inform staff in writing regarding the new auditing process prior to commencement. D) Auditor will generate timely reports and present findings for discussion in the QIC meeting. Ongoing in-services to continue. Upper management restructuring to occur over the next month. A to include the above deficiency on its calendar and in its Tickler system. Unacceptable Bright Burkin 12/4/09 Director	1/30/10 BBP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1330	Continued From page 17 hire date of 3/06/09. The personnel record lacks documentation of the required ppd skin test prior to employment. 2) Employee #5 (RN) has a hire date of 7/30/07. The personnel record lacks documentation of an annual required PPD for the year 2009. 3) Employee #6 (RN) has a hire date of August 2007. The personnel record lacks documentation of an annual PPD for the year 2009. 4) Employee #7 (RN) has a hire date of 4/24/06. The personnel record lacks documentation of the required PPD prior to employment and annually. During an interview on 11/03/09 with the agency Owner, the Owner did not provide an explanation for the employees not receiving PPD/Mantoux testing.	H1330		
H1332	766.11(d)(5) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact: (5) an annual, or more frequent if necessary, health status assessment to assure that all personnel are free from any health impairment that is of potential risk to the patient, family or to employees or that may interfere with the performance of duties. This Regulation is not met as evidenced by:	H1332	SR Brigit Rhoden 12/4/09 Owner	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1332	Continued From page 18 Based on record reviews and staff interview, the agency failed to perform annual health assessments for employees. This was evident in three (3) of eight (8) personnel records reviewed. (Employees #5, #6, and #7) Failure to perform annual health assessments for employees places all patients at risk for exposure potential health risks. The findings are: 1) Employee #5 is a Registered Nurse (RN) with a hire date of July 30, 2007. The personnel record lacks documentation of an annual health assessment for the year 2009. The last documented health assessment is dated "September 2008". 2) Employee #6 is a RN with a hire date of August 2007. The personnel record lacks documentation of an annual health assessment for the year 2009. The last documented health assessment is "9/22/08". 3) Employee #7 is a RN with a hire date of 4/24/06. The personnel record lacks documentation of pre-employment health assessment for year 2006 and annual health assessments for years 2007, 2008 and 2009. During interview with the agency's Owner on 11/03/09, the Owner did not provide an explanation for the lack of annual employee health assessments:	H1332	H1332 766.11 (D) (5) Personnel A) the director of nursing shall ensure that all personnel have a complete annual health assessment. B) The director of nursing has obtained up to date annual health assessments on all currently employed personnel/ available to the DOH upon their request. C) The newly appointed QIC Czar to monitor staff files monthly starting 12/10/09- monthly at times 2 till 100% compliance is met, then quarterly. QI auditing tool to be updated as necessary. The director of nursing will inform the staff in writing regarding the new auditing process prior to commencement. D) The governing authority will include the deficiency H1132 in its tickler system/ GA calendar. The QI czar to provide written reports monthly or quarterly as needed. Upper management restructuring to occur over the next month. The GA /operator to include H1332 on its Calendar and in its Tickler system. unacceptable	12/15/09 BP
H1350	766.11(k) Personnel 766.11 Personnel.	H1350	Brigit Durkin 12/4/09 Owner	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1350	Continued From page 19 The governing authority or operator shall ensure for all health care personnel: (k) that an annual assessment of the performance and effectiveness of all personnel is conducted including at least one in-home visit to observe performance, if applicable. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to complete annual assessments of the performance and effectiveness of personnel which includes at least one in-home observation. This was evident for two (2) of seven (7) employees requiring annual performance evaluations (Employees #4 and #7). Failure to perform an annual performance assessment of staff which includes at least one in-home observation places all patients at risk for poor quality care. The findings are: 1) Employee #4 is a Physical Therapy (PT) with a re-hire date of 10/21/06. The personnel record lacks annual performance assessments for years 2007 and 2008. 2) Employee #7 is a Registered Nurse (RN) with a hire date of 4/24/06. The personnel record lacks annual performance assessments for years 2007 and 2008. During an interview with the agency's Owner on 11/03/09, the Owner did not provide an explanation for the missing performance assessments. REPEAT DEFICIENCY FROM 7/17/2007 SURVEY	H1350	H1350 766.11 (K) Personnel A) The director of nursing shall ensure that all personnel have complete up to date annual performance assessments B) The director of nursing has obtained all up to date annual in home performance assessments on all currently employed personnel available to DOH upon request. C) The newly appointed QIC czar to monitor employee files monthly times 2 till 100% compliance is obtained. Then quarterly QI auditing tool to be updated as necessary. The director of nursing will inform the staff in writing regarding the new auditing process prior to commencement D) Upper management restructuring will occur over the next month. The GA will include deficiency H1350 on its calendar ad in its Tickler system. The QI Czar to provide written monthly report or quarterly as needed. unacceptable Bright Nwoke 12/4/09 Owner	12/15/09 VSP

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	766.11(l)(1) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (l) (1) that a program is implemented and enforced for the prevention of circumstances which could result in an employee or patient/client becoming exposed to significant risk body substances which could put them at significant risk of HIV or other blood-borne pathogen infection during the provision of services, as defined in sections 63.1 and 63.9 of this Title. Such a program shall include: (i) use of scientifically accepted protective barriers during job-related activities which involve, or may involve, exposure to significant risk body substances. Such preventive action shall be taken by the employee with each patient/client and shall constitute an essential element for the prevention of bi-directional spread of HIV or other blood-borne pathogen; (ii) use of scientifically accepted preventive practices during job-related activities which involve the use of contaminated instruments or equipment which may cause puncture injuries; (iii) training at the time of employment and yearly staff development programs on the use of protective equipment, preventive practices, and circumstances which represent a significant risk for all employees whose job-related tasks involve, or may involve, exposure to significant risk body substances;	H1354	H1354 766.11 (1) Personnel A) The director of nursing shall be the designated individual responsible for the implementation of a Caring Hands Home Care in-service of blood-borne pathogens related risks and health care workers infection control state mandated in-service. B) According to the agency's personnel policy all staff will receive annual blood borne pathogen in-services and infection control in-services. All current employees of Caring Hands Home Care have been in-serviced and updated on infection control and blood borne pathogens. Available to DOH upon request. All staff has received a written notification of this update in the policy and Procedure. C) The new QIC Czar to review monthly 2 times till 100% compliance is met. In-services to be included on the employee audit tool staff to be notified in writing of the changes in in-services by 12/10/09. QIC to meet and discuss findings at 12/15/09 QIC meeting. D) The governing body/operator to include DOH deficiency H1354 on the GA calendar and tickler system QIC to review. Qic minutes to be reviewed ongoing.	12/15/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	Continued From page 21 (iv) provision of personal protective equipment for employees which is appropriate to the tasks being performed; (v) a system for monitoring preventive programs to assure compliance and safety. This Regulation is not met as evidenced by: Based on personnel record reviews and staff interview, the agency failed to ensure that employees receive annual Standard Precautions training. This was evident in four (4) of eight (8) personnel records reviewed. (Employees #1, #2, #7, and #8) Failure to ensure that employees receive the required annual in-service places patients at risk for poor quality care. The findings are: 1) Employee #8 Registered Nurse (RN) has a hire date of 3/06/09. The personnel record lacks documentation that the employee received Standard Precautions training during orientation. 2) Employee #1 RN has a hire date of April 2006. The personnel record lacks documentation of the required annual Standard Precautions training for the years 2007 and 2008. 3) Employee #2 is a RN with a hire date of 4/15/06. The personnel record lacks documentation of the required annual Standard Precautions training for years 2007 and 2008. 4) Employee #7 is a RN with a hire date of 4/24/06. The personnel record lacks documentation of the required annual Standard Precautions training for years 2007 and 2008.	H1354	→ Accepted 12/7/09 SR Bright Light 12/4/09 Owner	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1354	Continued From page 22 During an interview with the agency's Owner on 11/03/09, the Owner did not provide an explanation for the employees not receiving Standard Precautions training.	H1354	H1432 766.12 (A) (3) Records and reports A) The newly appointed czar Catherine McLaughlin is the designated individual responsible for correction and compliance of DOH repeated deficiency from 7/17/07 B) An emergency QIC meeting has been scheduled for 12/15/09 QIC is to include C.M. RN (czar) B.D. RN (dir. Of Nsg) and another member to be named. All DOH deficiencies, corrections, chart audits and employee file audits to be reviewed by the GAC on 12/20/09 C) QIC minute review to be included on the GA calendar and tickler system. D) The governing body/ operator will perform biannual review of minutes to ensure the QIC has adequately covered QIC meeting and other regulatory body information accordingly. Upper management changes to occur over the next month.	1/30/10
H1432	766.12(a)(3) Records and reports 766.12 Records and reports. (a) The governing authority or operator shall ensure the prompt submission of all records and reports required by the department and that: (3) at a minimum, the following reports and records are retained by the home care services agency and available to the department upon request: (i) minutes of the meetings of the governing authority and the committees thereof which shall be retained for three years from the date of the meeting; (ii) records of all financial transactions directly related to delivery of patient care which shall be retained three years from the date of the transaction; (iii) personnel records, which shall be retained three years from the date of employee termination or resignation; (iv) records of grievances and complaints which shall be retained for three years from the date of resolution; (v) all records related to patient care and services; and (vi) any other records required to be kept by this	H1432		

Brigit Rankin
Owner 12/4/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1432	Continued From page 23 Part or Part 765. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to maintain accurate Quality Assurance (QA) meeting minutes for the years 2006 - 2008. The GA's alteration of QA meeting minutes places all patients at risk for poor quality care. The findings are: A request for QI meeting minutes from 2008 - present was made during the entrance conference. Multiple requests were again made to the Owner for QI meeting minutes to be reviewed. The minutes dated "9/08/2008" and the "Oct. 5, 2008" sign in sheet document that the dates of both of these documents were altered. The QI meeting minutes dated 09/08/08 and 10/05/08 were identical minutes for the year 2006. The number "six (6)" in the date (2006) was altered and changed to an eight (8) (2008). During an interview with the Owner on 11/03/09, the Owner stated: "OK, I did not have any (QI) meetings in 2008". REPEAT DEFICIENCY FROM 7/17/2007 SURVEY	H1432		
H1454	766.12(c) Records and reports 766.12 Records and reports. (c) The home care services agency shall furnish annually to the department a copy of:	H1454	SR	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	LC0921A	A. BUILOING _____ B. WING _____	11/03/2009

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H1454	Continued From page 24 (1) statistical summaries of all health care services delivered on forms provided by the department; (2) if a for-profit corporation, a list of the principal stockholders and the number and percent of the total issued and outstanding shares of the corporation held by each, duly certified by the secretary of the corporation as to completeness and accuracy; (3) if a not-for-profit corporation, a list of directors, officers and corporate members, if such members number 10 or fewer; and (4) other such records and reports as may be legally required by the department. (d) The agency shall furnish simultaneously to the department copies of all notices and documents required to be filed with the Securities and Exchange Commission. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to submit complete reports for 2005 - 2007. This was evident for the agency's submission of statistical summaries. The finding is: The agency's submission of statistical reports documents that the agency has only "Pending" data with errors submitted for the years 2005 - 2007. There is no documented evidence that the agency submitted a 2007 supplemental report or a 2008 statistical report. The agency's Owner was made aware of the missing information during the entrance	H1454	H1454 766.12 Records and reports statistical report A) the governing authority/ operator will be the individual responsible for correction and ensuring compliance. B) The statistical reports for 2007 and 2008 are completed and up to date. Available upon request. C) To prevent re-occurrence of this issue and or similar issues a specific period for regulatory body updates are to be included in the QIC meeting of 12/15/09 in-services of designated personnel prior to meeting. The in-services are designated to meet compliance ongoing. D) QIZ czar to include statistical reports in QI audit tool/reports to be submitted to QA quarterly and monthly until compliance is met. The governing body/operator will conduct biannual review of minutes to ensure the QIC has adequately covered this topic and other regulatory body information accordingly The GA to include deficiency H1454 on its calendar and in its Tickler system. Overall systematic changes to be made over the next month. Brigit Durkin 12/4/09 Aliene	11/30/09 BD 12/4/09 BD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1454	Continued From page 25 conference on 11/03/09. No further information and explanation was provided by the Owner.	H1454	→ Accepted 12/7/09 SR	

12/4/09
Brigit Durkin 12/4/09
(owner)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0921A	A. BUILDING _____ B. WING _____	11/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HOME CARE INC	36 JANICE LANE SELDEN, NY 11784

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1454	Continued From page 25 conference on 11/03/09. No further information and explanation was provided by the Owner.	H1454	All attachments reviewed 12/28/09 SR. 1/20/10 Amended Brigit Rivkin CEO 12/21/09	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

October 28, 2009

Visiting Nurse Service of New York
Attn: Elizabeth Buff
VP for Quality Services & Clinical Excellence
1250 Broadway
New York, NY 10001

Re: Plan of Correction/CHHA
Provider: 337008
Survey Date: September 24, 2009

Dear Ms. Buff:

Please be advised that this office has reviewed the Plan of Correction relating to the recent Complaint Investigation Survey of your Certified Home Health Agency.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies cited.

If you have any questions regarding this matter, please contact this office at (212) 417-5888.

Sincerely,

Cheryl Phoenix-Tannis, RN. MSN, CS
Program Manager
MARO – Home Care, Hospice, and Adult Services

/jt

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING _____ B. WING _____	C 09/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 159	INITIAL COMMENTS An onsite complaint investigation was conducted on 9/24/09. (Complaint#NY00075471) The Complaint log was reviewed. The following staff were interviewed: Vice President of Quality Services, Director of Quality Management. Three (3) Clinical records were reviewed and identified as Patients # 1-3. 484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to provide home health aide services in accordance to the Plan of Care. This was evident in one (1) of three (3) clinical records reviewed. (Patient # 1) Failure to implement physician orders in the Plan of Care places the patient at risk for not receiving services as needed. The findings are: Patient # 1 has a start of care date of 4/25/09 with diagnoses which include Diabetes, Hypertension,	G 000 G 159	VNS Home Care submits that its policies, systems and procedures relating to patient care and its comprehensive quality management program for monitoring patient care are appropriate and satisfy both federal and state requirements. It is also important to make clear that the submission of this Plan of Correction is not to be construed as an admission that the cited deficiencies are accurate or that at the time of the survey the agency did not have policies, procedures and systems in place to ensure compliance with federal and state law. **I. Plan for Allegedly Affected Patient** **Delay of home health aide service start until 5/15/09:** Investigation of this case (Patient # 1) revealed that alteration in the frequency and duration of Home Health Aide services from frequency and duration documented in the plan of care initiated 4/25/09 was properly conducted and appropriate but was not properly documented in the patient's record as per the following circumstances: • The start of care date was 4/25/09 but the home health aide service was not started until 5/15/09 • At the patient's request, HHA service start was delayed because the patient had personal issues which needed attention. The patient's mother was ill in a Brooklyn Hospital and her deceased sister's children needed her oversight at school as well as at requested court dates. Service was initiated on 5/15/09 at the patient's request.	

Acceptable POC A. Williams RN 10/23/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Elizabeth Buff
Registered Dietitian

TITLE
Vice President for Quality Services & Clinical Excellence

(X6) DATE
10/20/2009
10/20/09

A. ...ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING _____ B. WING _____	C 09/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 159	Continued From page 1 Seizure Disorder, Osteoarthritis, Hyperthyroid, Depression. The plan of care initiated on 4/25/09 documents a physician order for "home health aide 2-3 hrs/day for 2-3 days/wk for 6 wks." The clinical record documents that the agency provided home health aide services on "5/15/09". The plan of care dated 4/25/09 – 6/24/09 and 6/25/09 – 8/22/09 documents a physician order for: "home health aide 2-3 hrs/day for 2-3 days/wk for 6 wks." There is no documentation that the agency provided hha services 6/9/09 – 6/22/09 On 9/24/09 at 3 pm, the Director of Quality Assessment/Management was interviewed and stated: "We will look for additional documentation."	G 159	• Corrective action was taken to enter addendum documentation to the patient's record to reflect the above. **No documentation of home health aide service provided 6/9/09-6/22/09:** • There is no documentation that the agency provided HHA services 6/9/09 to 6/22/09 because the final date of HHA service was 6/8/09. The early termination of the HHA service was because of the inconsistent availability of the patient. The patient also had 17 dogs that she refused to lock up which represented a safety issue for the HHAs. The physician agreed to the discontinuation of the HHA. • Corrective action was taken to enter addendum documentation to the patient's record to reflect the above. Patient #1 was discharged on 8/22/09. Acceptable Plan of Correction. N. Johnson 10/23/09	Completion Date: September 25, 2009 Completion Date: September 25, 2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Elizabeth Buff

TITLE
Vice President for Quality Services & Clinical Excellence

(X6) DATE
10/20/2009

...eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other ...afeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a ...lan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available ... the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING _____ B. WING _____	C 09/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
			II. Plan to Identify Other Potentially Affected Patients The Quality Management staff will review the case records of all the patients assigned to this nurse to assess her compliance with agency policy for "Plan of Care Development, Implementation, Coordination, and Evaluation" in meeting agency expectations that the plan of care is updated to accurately reflect the services being followed and to identify other potentially affected patients. Any issue in not updating the Plan of Care to accurately reflect that HHA services are being followed in accordance with the Plan of Care that is identified will be brought to the nurse's attention by the Queens Clinical Director and/or the Patient Service Manager and corrective action will be taken where indicated.	Completion Date: November 16th, 2009
			III. Measures and Systems The Quality Improvement Director has reviewed the current policy for "Plan of Care Development, Implementation, Coordination, and Evaluation" to evaluate the need for revision. The current policy requires no revision. The Queens Regional Administrator and Clinical Director will review the above SOD with the Patient Service Manager and the nurse involved with the SOD and review the agency policy for "Plan of Care Development, Implementation, Coordination, and Evaluation" and the nurse's responsibility for following agency policy.	Completion Date: October 19th, 2009 Completion Date: October 30th, 2009

Acceptable Plan of Correction. N Feldman 10/27/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Elizabeth Buff
Elizabeth Buff

TITLE
Vice President for Quality Services & Clinical Excellence

(X6) DATE
10/20/2009
10/20/09

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING _____ B. WING _____	C 09/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
			The Queens Regional Administrator and Clinical Director will review the above SOD with the team involved with the SOD and review the agency policy for "Plan of Care Development, Implementation, Coordination, and Evaluation" and the nurses' responsibility for following agency policy.	Completion Date: October 30th, 2009
			At the next regional staff meeting, the Queens Regional Administrator and/or Clinical Director will review the above SOD and the agency policy for "Plan of Care Development, Implementation, Coordination, and Evaluation". The staff's responsibility for following agency policy will be reviewed.	Completion Date: December 9th, 2009
			The Quality Improvement Director will develop a case review tool that will be used for concurrent review of randomly selected patient records to monitor compliance with ordered HHA services on the Plan of Care.	Completion Date: October 23rd, 2009
			The Quality Management staff will initiate an audit of randomly selected concurrent patient records on this team to determine if a pattern of noncompliance to agency policy exists. If a pattern is identified, further monthly auditing and staff remediation will take place. Any issue in not updating the Plan of Care to accurately reflect that HHA services are being followed in accordance with the Plan of Care that is identified will be brought to the nurses' attention by the Queens Clinical Director and/or the Patient Service Manager and corrective action taken.	Completion Date: November 30th, 2009

Accountable Plan of Correction, Column C 10/27/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Elizabeth Buff
Elizabeth Buff

TITLE
Vice President for Quality Services & Clinical Excellence

(X6) DATE
10/20/2009
10/20/09

...eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING _____ B. WING _____	C 09/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
			IV. Monitoring Systems The Quality Improvement Director will oversee the monitoring process for this SOD. A report will be prepared for any patterns identified and provided to the: • Chief Operating Officer • Vice President for Quality Services • Vice President of Operations for Acute Care • Quality Improvement Director • Regional Administrator for the Queens office • The Patient Service Manager for this team • The staff nurses assigned to this team Findings and actions resulting from this audit will also be reported at quarterly Professional Advisory Committee, Board Quality Committee, and Board of Director meetings.	Completion Date: December 31st 2009 Completion Date: March 31st 2010

Acceptable Plan of Correction. 10/21/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Elizabeth Buff

TITLE
Vice President for Quality Services & Clinical Excellence

(X6) DATE
10/20/2009

A... ...eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office
90 Church Street New York, NY 10007

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

April 23, 2009

Visiting Nurse Service of New York Home Care
Attn: Elizabeth Buff, VP for Quality Services & Clinical Excellence
1250 Broadway
New York, NY 10001

Re: Response to Plan of Correction
Survey Date: March 31, 2009
License: 337008

Dear Ms. Buff:

Please be advised that the Plan of Correction relating to the recent Re-certification survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please contact (212) 417-5888.

Sincerely,

C. Phoenix-Tannis MP

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Offices

/jt

Visiting Nurse Service Of New York
HomeCare™
We Bring The Caring Home™
1250 Broadway, New York NY, 10001

April 21, 2009

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Care, Hospice Services
State of New York, Department of Health
90 Church Street
New York, NY 10007

Re: Re-Certification Survey
Provider: #337008
Survey Date: March 31, 2009

Dear Ms. Phoenix-Tannis:

In response to your letter dated April 14, 2009, attached you will find our Agency's plan of correction for the above-cited survey. If you have any questions please call Peter Ungvarski, Liaison for Regulatory Compliance at 212-609-6355 or Elizabeth Buff, Vice President for Quality Services & Clinical Excellence at 212-609-6334.

Sincerely,

Elizabeth Buff
Vice President for Quality Services & Clinical Excellence

RECEIVED
APR 2 1 2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G000	INITIAL COMMENTS A Recertification Survey was conducted at Visiting Nurse Services on March 23, 2009 through March 31, 2009. Twenty five (25) clinical records were reviewed and identified as Patients #1 through #25. The record reviews were inclusive of three complaint investigations: #NY0066933 (CR #1), #NY 0069221 (CR #2) and #NY 0068651 (CR#3) Four (4) of the clinical records reviewed were patients receiving services from the Long Term Home Health Care Program (LTHHCP), (Patients #3, #16, #17, and #25). Ten (10) home visits were made to Patients #4, #5, #6, #12, #13, #14, #15, #16, #17 and #18. Two (2) of the home visits were made to patients receiving services from the LTHHCP (Patients #16 and #17). Eleven (11) personnel records were reviewed and identified as Employees #1 through #11.	G000	VNS Home Care submits that its policies, systems and procedures relating to patient care and its comprehensive quality management program for monitoring patient care are appropriate and satisfy both federal and state requirements. It is also important to make clear that the submission of this Plan of Correction is not to be construed as an admission that the cited deficiencies are accurate or that at the time of the survey the agency did not have policies, procedures and systems in place to ensure compliance with federal and state law.	
G 143	484.14(g) CORRDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidence by: Based on record reviews and interview, the agency failed to coordinate of patients' Plan of Care. This was	G143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued from page 1 evident for 7 (seven) of twenty five (25) clinical records reviewed. (Patients # 8,12, 15,16,17, 24, and 25) Failure to coordinate patient services has the potential for substandard care. The findings are: 1.Patient #16 (HV) was admitted to the agency on 3/05/09 with diagnosis of Congestive Heart Failure, Coronary Artery Disease, Cardiac Defibrillator Implant Replacement, Hypertension and Dementia. During the certification period of 3/05/09 to 5/03/09, the physician ordered social work services for one (1) to two(2) times a month for two (2) months. The clinical record documents that the initial visit was made on 3/24/09. There is no further documentation of social work visits during this time period. 2.Patient #17 (HV) was admitted to the agency on 2/27/09 with diagnosis of Diabetes Type2, Hypertension , Malignant Neoplasm Colon, Joint Pain of Pelvis, Seizure Unspecified and Muscle Weakness. During the certification period 2/27/09 to 4/27/09, the physician ordered social work services for one (1) to two (2) times a month for two (2) months.	G143	**I. Plan for Allegedly Affected Patients** • **Plan for Follow-up for Patient#16:** Patient #16 was discharged 04/08/09 The Clinical Director for LTC and Social Work Manager will meet with the Social Worker involved in this patient's care and review the SOD and her responsibility to follow the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames. The Social Worker visited according to the Plan of Care: in March a visit was made on 3/24/09 and once in April on 4/1/09 prior to discharge (physician ordered social work services for one (1) to two(2) times a month for two (2) months.) • **Plan for Follow-up for Patient#17:** Patient #17 is active. The Clinical Director for LTC and Social Work Manager will meet with the Social Worker involved in this patient's care and review the SOD and the Social Worker's responsibility to follow the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames.	Completion Date: May 8, 2009 Completion Date: May 8, 2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued from Page 2 The clinical record documents a social work initial visit on "3/13/09". There is no further documentation of social work Visits during this period. A nutrition assessment and visits were ordered by the physicians on "2/27/09" for one (1) to two (2) times a month for two (2) months. The clinical record documents the initial nutrition assessment was made on "3/03/09". There is no further documentation of nutrition visits during this period. 3. Patient #25 was admitted to the agency on 2/26/09 with diagnosis of Diabetes Type2, Hypertension, Congestive Heart Failure, Depression and Joint Replacement Hip. During the certification period 2/26/09 to 4/26/09, the physician ordered social work visits for one (1) to two (2) times a month for two (2) months	G143	The Social Worker is visiting according to the Plan of Care: in March a visit was made on 03/13/09 and then on 03/27/09 and in April on 04/10/09 (physician ordered social work services for one (1) to two(2) times a month for two (2) months.) The Dietician involved in this patient's care followed the agency's policy for "First Visit" in ("within five (5) working days "). The patient was admitted on Friday February 27 and 5 working days – excluding Saturday and Sunday – means that the first visit should have been made by 3/6/09 and it was in fact made on 3/3/09. The Dietician is visiting according to the Plan of Care: in March a visit was made on 3/9/09 and in April on 04/06/09 (physician ordered nutrition services for one (1) to two(2) times a month for two (2) months.) **Plan for Follow-up for Patient#25** Patient #25 was discharged on 03/26/09. The Clinical Director for LTC and Social Work Manager will meet with the Social Worker involved in this patient's care and review the SOD and the Social Worker's responsibility to follow the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames.	Completio Date: May 8, 2009 Completio Date: May 8, 2009 acceptable

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued from Page 3 The clinical record documents the social work initial visit was made on "3/30/09". There is no further documentation of social work visits during this period The Clinical Director and Administrator of the Long Term Home Health Care program was interviewed on 3/27/09 at 1:30pm and confirmed that the services had not been provided as ordered in the Plans of Care and this "was no in accordance "with the agency policy which states that the agency will provide Social Work (SW) services and Nutrition services for patient within five (5) working days of the referral 4.Patients #12 (HV) was admitted to the agency, on 12/31/08 with diagnosis of Lower Leg Injury, Pressure Ulcer, Diabetes Type2, Difficulty on walking , Dementia and Hypertension. During the certification period 12/24/08 to 2/21/09, the physician ordered social work visits for one (1) to two (2) times a month one (1) month. The clinical record documents the social work initial assessment was made on "1/13/09". There is no further documentation of social work visits during this period	G143	No Social Work visits were made before discharge. **Plan for Follow-up for Patient#12** Patient #12 is active. The Clinical Director for the Bronx and Social Work Manager will meet with the Social Worker involved in this patient's care and review the SOD and the Social Worker's responsibility to follow the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames. They will also review the agency policy for coordination of care. When the Social Worker called to schedule a visit in February the patient's son declined and the plan of care was not modified to reflect the patient's needs. The Clinical Director for Congregate Care and the Patient Service Manager will meet with the	Completion Date: May 8, 2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	**Vice President for Quality Services & Clinical Excellence**	**04/21/2009**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued From page 4 5. Patient #24 was admitted to the agency on 2/07/09 with diagnosis of Coronary Artery Disease, Congestive Heart Failure, Atrial Fibrillation, Hypertension and Glaucoma During the certification period 2/07/09 to 4/07/09 the physician ordered social work visits for two (2) to four (4) times a month for one (1) month. The Clinical record documents the social work initial visit was made on 2/15/09. There is no further documentation of social work visits during this period. The Quality Improvement Specialist of the Certified Home Health agency was interviewed on 3/30/09 at 1:00pm and confirmed that the services had not been provided as ordered in Plans of Care.	G143	Coordinator of Care and involved in this patient's care and review the SOD and the Nurse's responsibility in modifying and maintaining the plan of care to reflect exact services provided for the patient. **Plan for Follow-up for Patient#24** Patient #24 was discharged on 04/06/09. The Clinical Director for Congregate Care will meet and Social Work Manager will meet with the Social Worker involved in this patient's care and review the SOD and the Social Worker's responsibility to follow the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames. They will also review the agency policy for coordination of care. The Clinical Director for Congregate Care and the Patient Service Manager will meet with the Coordinator of Care and involved in this patient's care and review the SOD and the Nurse's responsibility in modifying and maintaining the plan of care to reflect exact services provided for the patient.	Completion Date: May 8, 2009 Completion Date: May 8, 2009 Completion Date: May 8, 2009

accepted
4/2

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	**Vice President for Quality Services & Clinical Excellence**	**04/21/2009**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued From page 5 6.Patient #8 was admitted to the agency with a diagnosis of Diabetes Type2, Morbid Obesity, Hypertension, Depression, Hyperlipidemia and Difficulty in Walking. The initial plan of care dated 2/24/09 documents orders for the following : Physical Therapy one (1)n to (3) times per week For nine weeks to teach, activities in daily living training, therapeutic exercises, gait training, coordination/ balance activities and transfer training. Nutritionist one (1) to (2) times per week for four weeks to assess for nutritional needs/ intake. The clinical record documents a Physical Therapy note dated "3/20/09". There is no documented evidence of a Physical Therapy visit between the date of the order and 3/20/09. The clinical record documents a Nutritionist note dated "3/17/09". There is no documented evidence of a Nutritionist visit between the date of the order and 3/17/09. The agency Policy and Procedure for "Provision of Services" documents that services are to be provided "within five (5) working days of order by the physician " 7.Patient #15 was admitted to the agency with a diagnosis of Liver Disorder, Hypertension, Kidney Cyst, Coronary Artery Disease, Dementia and Difficulty in walking. The initial plan of care dated 3/13/09 documents	G143	**Plan for Follow-up for Patient#8** Patient #8 is active. The Clinical Director for Queens Acute Care and the Patient Service Manager will meet with the Coordinator of Care and involved in this patient's care and review the SOD and the Nurse's responsibility in modifying and maintaining the plan of care to reflect exact dates and times of requests. The nurse placed Physical Therapy and Nutrition Services on the initial plan of care but did not make requests for these services at the same time. **Plan for Follow-up for Patient#15** Patient #15 is active. The Director of Rehabilitation QA/education and Rehabilitation Manager will meet with the Physical Therapist involved in this patient's care	Completion Date: May 8, 2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
...zabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued From page 6 orders for the following: Physical Therapy Evaluation for gait training. The clinical record documents a Physical Therapy note dated "3/27/009". There is no documented evidence of a Physical Therapy visit between the date of the order and 3/27/09. On 3/27/09 at 3pm the Quality Improvement Specialist was interviewed and stated that the agency "did not send" the Physical Therapist or Nutritionist within the timeframe outlined in the Agency Policy.	G143	and review the SOD and the Physical Therapist's responsibility to follow the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames A Nutritionist was never ordered for this patient. **II. Plan to Identify Other Potentially Affected Patients** The Social Work Managers, Patient Service Managers, and Rehabilitation Managers and will randomly select records of the staff identified in the SOD to assess their compliance with the agency's policy for "First Visit" in meeting the agency expectations that the scheduling of the initial visit is made within the specified time frames and to review their ability to maintain or modify the plan of care when indicated regarding visit frequency as well as to confirm the steps/actions outlined in Section I were effective and to identify other potentially affected patients.. The Vice President for Quality Services and Liaison for Regulatory Compliance reviewed and revised the agency quality assurance monitoring plan for 2009 to include concurrent review of patient records to monitor compliance with agency policies for initiating the first visit for social work, rehabilitation therapy and nutrition services as well as following the plan	Completio Date: May 8, 2009 Completio Date: May 24, 2009 Implemen ation Date June, 200

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G143	Continued From page 7	G143	of care for such services in order to identify other potentially affected patients.. **III. Measures and Systems** The Vice President for Quality Services and Liaison for Regulatory Compliance will review the current policies for "First Visit" and "Interdisciplinary Coordination of Care" to evaluate the need for revision. The Regional Administrators and Program Directors throughout the agency will meet with the staff and review this SOD and in-service all nurses, social workers therapists and Dieticians regarding the agency policy for "First Visit" and "Interdisciplinary Coordination of Care" and their responsibilities for following agency policy. The Vice President for Quality Services & Clinical Excellence and Regulatory Compliance Liaison will develop a process for on-going case reviews for 2009 that will monitor not only the initial visits made by social workers, therapists and dieticians but also their compliance with the visit frequency in the plan of care. The agency has developed a plan and process to include social workers in the electronic patient record in order to facilitate and improve interdisciplinary communication and compliance with the plan of care. This training process is currently in progress.	Completion Date: May 1, 2009 Completion Date: June 26, 2009 Implement ation Date: June, 2009 Implement ation Date: 2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337008	A. BUILDING B. WING	03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNS OFNY HOME CARE CHHA	107 EAST 70TH STREET NEW YORK, NY 10021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
G143	Continued From page 8	G143	**IV. Monitoring Systems** The Vice President for Quality Services & Clinical Excellence and Manger for Quality Improvement oversee the on-going monitoring process for this SOD and produce monthly "Compliance Scorecards" that will be provided to the: • Chief Operating Officer • Vice Presidents of Operations • Regional Administrators • Program Directors • Clinical Directors • Patient Service Managers • Rehabilitation Managers • Social Work Managers • Clinical Staff Findings and actions taken to address areas that do not meet agency thresholds will also be reported at quarterly Professional Advisory Committee, Board Quality Committee, and Board of Director meetings and to the Chief Executive Officer.	Implement ation Date: July, 2009 Implement ation Date Third Quarter 2009

acceptable 4/22/

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Buff	Vice President for Quality Services & Clinical Excellence	04/21/2009

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337213	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER JEWISH INST FOR HEALTH CARE &	1 DELAWARE DRIVE SUITE 104 NEW HYDE PARK, NY 11042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 720	763.7(a)(3)(ii) Clinical Records 763.7 Clinical Records. (a) The agency shall maintain a confidential clinical record for each patient admitted to care or accepted for service to include: (3) Medical orders shall be: (ii) signed by the authorized practitioner within 30 days after issuance of any change in medical orders or prior to billing, whichever is sooner, to include all written and oral changes and changes made by telephone by such practitioner; and This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure that Medical Orders are signed by the Physician within thirty (30) days. This was evident in ten (10) of seventeen (17) clinical records reviewed. (Patients #4, #5, #6, #9, #10, #11, #12, #14, #15, and #16). Failure to ensure that orders are signed by the physician within thirty (30) days places the patients at risk for not receiving ordered services. Findings are: 1) Patient #5 has an admission date of 9/25/09. The Plan of Care initiated on 9/25/09 lacks documentation of a physician's signature until 11/05/09. 2) Patient #6 has an admission date of 7/05/00. The Plan of Care initiated on 9/15/09 lacks	J 720	The following plan of correction is submitted in accordance with applicable law and regulation for continued Medicare/ Medicaid certification. J 720 I. The following action is being taken for the areas identified under this J tag. Patient #4- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #6- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #11- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #12- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #14- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #10- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #9- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician.	03/15/10 03/15/10 03/15/10 03/15/10 03/15/10 03/15/10 TN

FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337213	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER JEWISH INST FOR HEALTH CARE &	1 DELAWARE DRIVE SUITE 104 NEW HYDE PARK, NY 11042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 720	Continued From page 1 documentation of a physician signature until 10/19/09. The Plan of Care initiated on 11/14/09 lacks documentation of a physician until 12/26/09. 3) Patient #11 has an admission date of 8/05/09. The Plan of Care initiated on 10/04/09 lacks documentation of a physician's signature until 12/03/09. Interim Physician's Orders dated 10/16/09 and 10/20/09 lack documentation of a physician's signature until 12/05/09. The Interim Physician's Order dated 9/16/09 lacks documentation of a physician's signature. 4) Patient #12 has an admission date of 5/07/09. The Plan of Care initiated on 7/06/09 lacks documentation of a physician's signature until 8/17/09. The Plan of Care initiated on 11/03/09 lacks documentation of a physician's signature until 12/10/09. Interim Physician's Orders dated 5/11/09 and 5/12/09 lack documentation of a physician's signature until 7/20/09. 5) Patient #14 has an admission date of 5/14/09. The Plans of Care initiated on 9/11/09 and 11/10/09 lack documentation of physician signatures. Interim Physicians's Orders dated 10/27/09 lacks documentation of a physician's signature. 6) Patient #10 has an admission date of 9/18/09. The Plan of Care dated 11/ 17/09 - 1/15/10 lacks documentation of the physician's signature. Interim Physicians's Order dated 10/30/09 lacks	J 720	Patient #15- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #4- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. Patient #16- All services that the patient required were provided based on the Physician's verbal order. The lack of documentation of a Physician's signature on the Plan of Care within thirty (30) days will be addressed with this patient's Physician. A letter signed by the Medical Director and Administrator will be sent to each Physician notifying them that failure to sign a patient's orders within the specific thirty (30) day period may affect the patient's receipt of ordered services. II. The following corrective action will be implemented to identify other patients participating in the program that may be affected by the same practice: A report will be generated identifying all instances of unsigned orders, regardless of whether thirty (30) or more days have expired. The agency will follow-up with the relevant physician in all cases where we have yet to receive signed orders. The process identified in Section III will be followed, except in cases where the signed order is already late. In those cases, a copy of the orders will be sent promptly to the physician, with a letter, via return receipt request. Proactively, in April 2010, a full program printout of all 485s due during the upcoming week will be reviewed for timely signatures. Physicians who have outstanding orders will be contacted by the Medical Director.	03/15/10 03/15/10 03/15/10 03/15/10 03/05/10 04/15/10

FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337213	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER JEWISH INST FOR HEALTH CARE &	1 DELAWARE DRIVE SUITE 104. NEW HYDE PARK, NY 11042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 720	Continued From page 2 documentation of the physician's signature. 7) Patient #9 has an admission date of 9/10/02. The Plan of Care initiated on 12/02/09 lacks documentation of a physician's signature until 1/13/10. 8) Patient #15 has an admission date of 9/10/09. The Plan of Care initiated on 11/09/09 lacks documentation of a physician signature until 12/18/09. 9) Patient #4 has an admission date of 10/07/09. The Plan of Care initiated on 12/09/09 lacks documentation of a physician's signature until 1/12/10. 10) Patient #16 has an admission date of 2/09/09. The Plan of Care initiated on 10/06/09 and 12/05/09 lack documentation of physician signatures until 1/12/10. During an interview with the Administrator and the Director of Patient Services (DPS) on 1/13/10 were informed of the survey findings. On 1/14/10, the Administrator stated: "we have been having difficulty getting some physicians to sign the orders on time".	J 720	III. The following system changes will be implemented to assure continuing compliance with regulations: All Plans of Care will be printed by the first day of the certification period. All interim orders will be printed on the day the order is entered by the nurse. All orders will be faxed to those Physicians who accept facsimiles and then sent through the mail with a stamped, self-addressed return envelope. If the Physician does not accept facsimiles, the order will be mailed. If the order is not returned within 10 days, it will be sent via certified mail. If we do not receive the signed order within the next seven (7) days, the Nurse / Nursing Supervisor will call the Physician. If the signed order, within the next seven (7) days is still not received, a messenger will be sent to the Physician's office with another copy of the order, and request the Physician to sign it. If compliance is still not achieved, the agency will request that the patient take the orders to the Physician on their next visit, to have them signed. IV. The program's compliance will be monitored utilizing the following quality assurance system: The Performance Improvement Committee will review 20% of all orders sent out the previous month on a weekly basis. A compliance threshold of 85% within six (6) months will be achieved. If the threshold is not achieved, the physicians involved will be contacted by the Medical Director, who will report his achievements and recommendations at the next Professional Advisory Committee (PAC) meeting. Resp Person : Administrator Accepted 2/17/10 TN	03/19/10 02/05/10 02/05/10 03/19/10 03/26/10 04/02/10 05/01/10 10/01/10 11/01/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Re-Licensure Survey was conducted at Gentiva Health Services on 2/17/2010 and 2/18/2010. Five (5) Patient Care Records were reviewed and identified as Patients #1 to #5. One (1) Home Visit was made to Patient #1. Nine (9) Personnel Records were reviewed and identified as Employees #1 to #9. The following was reviewed during the survey: policies and procedures for the agency's Emergency Preparedness Plan, Health Provider Network and Directory, Criminal History Record Check, Clinical Supervision, On Call, Advisory Board of Directors, HIV Confidentiality, and Photo ID. The Complaint Log, Patient Information Admission Packets and Quality Assurance/Improvement Committee Meeting Minutes were reviewed.	H 000		
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available	H 204	***Actions for Specific Patients Affected:*** The Manager of Clinical Practice (MCP) provided corrective counseling and re-education to the RN Case Manager for patient #1 on 2/22/10 regarding the necessity to properly complete all consents to accurately reflect the services provided by the Licensed Agency and the need to document the Insurance Policy # on the consent as well. A corrected consent has been obtained for patient number 1. ***Measures or Systemic Changes to Prevent Recurrence:*** Mandatory meeting held on 3/3/10 for all clinicians. The Director of Clinical Operations and Services (DCOS) instructed all clinicians regarding the necessity to properly complete all consents to accurately reflect the services provided by the Licensed Agency and the need to document the Insurance Policy # on the consent. ***Please see Attachment D, sign-in sheet for Mandatory meeting of 3/3/10.*** Amended 4-T	2/22/10 3/3/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 1 by the agency and related charges; (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient. (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Regulation is not met as evidenced by: Based on record review, home visit (HV) and staff interview, the Governing Authority failed to ensure that the patients are provided accurate information regarding the available agency services and patient liability for services provided. This was evident in five (5) of five (5) records reviewed and one (1) of one (1) home visit (Patient #1). Failure to ensure that the patients are provided accurate information regarding the available agency services and liability, places the patients at risk for not being able to exercise rights. The findings are:	H 204	***QA Program to Monitor:*** ***The DCOS and Quality Assurance Nurse (QA RN) will conduct 2 months of 100% record review of all active charts, with an agency goal of 100% compliance with accurate completion of consents. 100 % audit will be ongoing until a 100% rate of compliance is achieved for 2 consecutive months; at such time auditing will be reduced to 50% of clinical records of active patients on a monthly basis with the goal of 100% rate of compliance. If this goal is not maintained, the agency will resume 100% audits until 2 consecutive months of compliance is achieved again. This will continue on an ongoing basis.*** In addition, if any clinician is found as a result of the audit to be deficient in the correct completion of the consent, he/she will be counseled regarding the necessity to properly complete all consents to accurately reflect the services provided by the Licensed Agency and to document the insurance policy # in the appropriate area of the consent. In addition, it will be required that the clinician obtain a new consent immediately that accurately reflects the services provided under the Licensed Agency. ***Measures or Systemic Changes to Prevent Recurrence:*** Gentiva's Compliance and Legal Department reviewed the deficiency findings and as a result the consent has been revised to omit all references addressing Medicare billing and services that are not on the agencies license (see Attachment A). The new form is being printed in duplicate and will be made available to caregivers. Attended xT	***6/14/10 and ongoing*** 5/15/10

Noel Montag, BD 4/8/10

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILOING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP COOE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 2 a) The "Home Care Consent" form for Patients #1 to #5 documents the following agency services: RN (Registered Nurse), LPN (Licensed Practical Nurse), Physical Therapy, Medical Social Services, Transportation, Housekeeping (or Homemaker), Speech/Language Pathology, Home Health Aide, Nutritional Services, Occupational Therapy and Hospice Services. The agency license dated 7/16/04 does not include the services of Transportation and Hospice Services. The agency revised license dated 4/23/2008 did not include the services of Transportation, Nutritional and Hospice Services. b) During home visit to Patient #1 on 2/17/10 with the agency's Nursing Supervisor, the Patient Information Packet was reviewed. The "Nutrition Services" is checked off by the nurse as an available agency service. The "Home Care Consent" form under section titled as "Authorization for Payment/Assignment of Insurance Benefits" documents "I certify that the information provided by me is correct. I authorize my insurance company (ies) including as appropriate Medicare, Medicaid and other governmental programs to furnish any agent of Gentiva Health Services any and all information pertaining to my insurance benefits and status of claims submitted by Gentiva Health Services". "I (patient signed her name) the insured, authorize payment directly to Gentiva Health Services for Medicare, Medicaid, or other government program benefits (as applicable) and other insurance benefits otherwise payable to	H 204	***Actions for Patients Potentially Affected and Measures or Systemic Changes to Prevent Recurrence:*** The updated consent will be utilized for all patients identified in the above referenced 100% audit requiring corrected consents. Additionally, the deficiencies noted for Patients 1, 2, 3, 4 and 5 will be rectified through the utilization of the updated consent; updated consents will be obtained. The new consent will be utilized going forward. ***Actions for Patients Potentially Affected and Measures or Systemic Changes to Prevent Recurrence:*** ***To identify patients having the potential to be affected by the same deficiency the DCOS and QA RN will conduct a 100% audit of all active charts. The MCPs will complete a 100% audit of consents at start of care to ensure that the correct services and insurance policy # are correctly entered on all consents for all patients. If any consents are found to be deficient, the clinician will be required to obtain a new consent immediately.*** ***QA Program to Monitor:*** ***Results of record audits will be presented to the Professional Advisory Committee (PAC) at PAC meetings and PAC input will be incorporated into the monitoring of records. PAC meeting minutes, including the reporting of the record audit results, will be sent to the Governing body.*** The DCOS will have overall responsibility to ensure that all corrective actions are completed. Amended XT	5/15/10 and ongoing ***6/14/10 and ongoing*** ***6/30/10***

Used Wintaff, BD 4/8/10
Accepted 4/12/2010
ECannon CNSC

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 3 under Policy #". This area on the form was found to be blank. The areas addressing Medicare billing and the documented services that are not on the agency's license were not crossed out on the form by the nurse. The licensed agency is not authorized to bill Medicare for agency services. During interview on 2/18/10 with the agency's Director of Clinical Services (DCS) and Nursing Supervisors, the DCS stated that the nurse "should have" documented the patient's insurance carrier on the consent form. The DCS did not provide an explanation for the inaccurate information documented on the agency's "Home Care Consent" form.	H 620	*Actions for Specific Patients Affected:* The clinician for patient #2 and #4 was counseled by the MCP regarding lack of notification of the physician regarding changes in the patient's clinical status (the size of the patient's wound) and the necessity to include the pressure setting of wound vac device as ordered by the physician in all documentation regarding care to a wound with a wound vac in place.	2/22/10
H 620	766.5(b)(4) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (4) plans of care are revised as needed and changes are reported to the patient's authorized practitioner, other staff providing care to the patient, and other agencies which authorize payment for services, as appropriate and necessary. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the professional staff		*Measures or Systemic Changes to Prevent Recurrence:* Mandatory meeting held on 3/3/10 for all clinicians. The Director of Clinical Operations and Services (DCOS) instructed all clinicians regarding the necessity of notification of physician of changes in patient clinical status (such as changes in wound size) and of the necessity to include the pressure setting of the wound vac device as ordered by physician in all documentation regarding care to a wound with a wound vac in place. *Please see Attachment D, sign-in sheet for Mandatory meeting of 3/3/10.* *Actions for Patients Potentially Affected and QA Program to Monitor:* *To identify patients having the potential to be affected by the same deficiency, and to ensure the deficient practice will not recur (QA program),the DCOS and Quality Assurance Nurse (QA RN)) will conduct 2 months of 100% record review of all active charts, with an agency goal of 100% compliance with compliance with notification of phyisican regarding changes in the patient's clinical status (the size of the patient's wound) and inclusion of pressure setting of wound vac.* Amended x 1	3/3/10 6/14/10 and ongoing

Wael Montasf, BD 4/8/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From page 4 perform the required wound care, inform the physician and nursing supervisor regarding changes in wound status and ensure that the ordered medications are current/updated as needed. This was evident in one (1) of four (4) patients requiring wound care (Patient # 4) and one (1) of five (5) patient care records reviewed (Patient #2). Failure to ensure that the professional staff provide the ordered patient services and inform the physician for changes in the patient clinical status, places the patients at risk for poor quality of care and unmet needs. The findings are: 1) Patient # 4 has an admission date of 7/01/2009 with the diagnoses including Non-Healing Surgical Wound, Diabetes Mellitus Type II and Hypertension (HTN). The Plan of Care dated 12/28/2009 to 2/25/2010 documents orders for the patient's wound care as: "cleanse with NS (normal saline) liquid or spray, pack with KCl White sponge and cover with occlusive dressing - VAC at 125mm/Hg change dressing 3 x (three times) weekly". The nursing visit note dated 12/23/09 documents the patient's wound dimensions as "5cm x 3.8cm x 0.3cm" The nursing visit note dated 1/04/2010 documents the patient's wound dimensions as "5.6cm x 2.5cm x 0.3cm" The nursing visit note dated 1/18/2010 documents the patient's wound dimensions as "6cm x 2.8cm x 0.3cm".	H 620	***100 % audit will be ongoing until a 100% rate of compliance is achieved for 2 consecutive months; at such time auditing will be reduced to 50% of clinical records of active patients on a monthly basis with the goal of 100% rate of compliance. If this goal is not maintained, the agency will resume 100% audits until 2 consecutive months of compliance is achieved again. This will continue on an ongoing basis.*** In addition, if any clinician is found as a result of the audit to be deficient in the above noted documentation, he/she will be counseled regarding the necessity of notification of physician of changes in patient clinical status (such as changes in wound size) and of the necessity to include the pressure setting of the wound vac device as ordered by the physician in all documentation regarding a wound with a wound vac in place. ***Measures or Systemic Changes to Prevent Recurrence:*** The agency will institute the use of a weekly wound assessment conference form (See Attachment B), which will enable the MCP to document conference with clinician weekly regarding: assessment of wounds, including location, size, amount and description of drainage, signs and symptoms of infection; notification of the physician of any changes in the wound; changes in care of the wound as ordered by the physician. The form will also include inquiry if wound vac is in use and serve as a reminder from MCP to clinician regarding the inclusion of physician ordered pressure settings fro all documentation of wound care to a wound with a wound vac in place. Use of this form will serve as deter recurrence in the deficient practice on an ongoing basis. Attended x I	5/15/10

Used Untaf. BD 4/8/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From page 5 The nursing visit notes did not document that the nurse had informed/notified the physician regarding the increase in wound size. During interview on 2/18/2010 with the agency's Director of Clinical Services (DCS) and Nursing Supervisors, the Nursing Supervisor stated that the nurse "should have informed the physician regarding the changes in the patient's wound status." The nursing visit notes dated 12/23/09 to 2/12/10 do not document that the nurse ensured that the wound VAC pressure was maintained at the ordered pressure of "125mm/Hg". The visit note dated 1/31/2010 documents that the patient called to inform the nurse that the VAC was "not holding" the required pressure. The note further documents that the nurse performed the wound care. There is no documentation that the nurse had restored the required wound VAC pressure of "125mm/Hg" as ordered by the physician. During interview on 2/18/2010 with the agency's DCS and Nursing Supervisors, the DCS stated that the nurse should have ensured that the wound VAC pressure was maintained/restored as per the physician's orders. 2) Patient #2 has an admission date of 11/21/2005 with the diagnoses including Paralysis Agitans, Pressure Ulcer Buttock and Hypertension. The Plan of Care dated 12/30/2009 to 2/27/2010 documents orders: "Flonase 50mg 1 (one) spray	H 620	***Measures or Systemic Changes to Prevent Recurrence:*** In order to monitor compliance and prevent recurrence of deficiency, the DCOS and QA RN will complete a 100% retrospective review of all patient charts upon discharge to ensure compliance with proper use of the Wound Care Assessment Conference update form (See Attachement B). Counseling of clinician will be completed if any deficiency is identified.	5/19/10 and ongoing
			QA Program to Monitor: ***Results of record audits will be presented to the Professional Advisory Committee (PAC) at PAC meetings and PAC input will be incorporated into the monitoring of records. PAC meeting minutes, including the reporting of the record audit results, will be sent to the Governing body.*** The DCOS will have overall responsibility to ensure that all corrective actions are completed.	6/1/10
			Actions for Specific Patients Affected: The MCP provided corrective counseling and re-education to the RN Case Manager for patient #2 on 2/22/10 regarding failure to update and keep current the medication profile in the patient's home and the patient's agency chart according to the MD orders for the discontinuation of medications, dosage adjustments and initiation of new medications. Amended x 1	2/22/10

Used Wentaff, BD 4/8/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From page 6 in each nostril daily, Musinex 600mg/300mg PO (by mouth) prn (as needed) and Ultracet 325/37.5mg 1 tablet daily as needed PO pm pain". The "Medication Profile" last updated on 12/29/09 did not document the above medications of Flonase, Mucinex and Ultracet 325/ 37.5mg. as per the Plan of Care. The "Medication Profile" documents the medication Ultracet as "325/375mg PO QID (four times a day)". The "Medication Profile" further documents the medication of "Lasix 20mg PO BID (twice a day)". The Plans of Care did not include the Lasix in the Plans of Care from 3/05/2009 to the present. The patient care record does not include documentation that the nurse had consulted with the physician to confirm the appropriate Ultracet dosage and medication regime for the patient. During interview on 2/18/2010 with the agency's DCS and Nursing Supervisors, the DCS stated that the nurse updated the patient's Medication Profile in the patient's home and failed to update the patient care record. During the survey, the agency did not provide the updated Medication Profile for review. The Plan of Care documents orders for the nurse to visit the patient "2 x mo x 2 mo (two times a month for two months) cardiovascular/hematological interventions, assess cardiovascular status. Neurological interventions assess neurological status, pain management and med (medication)	H 620	***Measures or System Changes to Prevent Recurrence:*** Mandatory meeting held on 3/3/10 for all clinicians. The Director of Clinical Operations and Services (DCOS) instructed all clinicians regarding the importance of updating and keeping current the medication profile in the patient's home and the patient's agency chart according to the MD orders for the discontinuation of medications, dosage adjustments and initiation of new medications. Clinicians were instructed to notify MCP regarding any medication changes noted during visits. ***Please see Attachment D, sign-in sheet for Mandatory meeting of 3/3/10.*** ***Actions for Patients Potentially Affected and QA Program to Monitor:*** ***To identify patients having the potential to be affected by the same deficiency, and to ensure that the deficient practice does not recur(QA Program) the DCOS and Quality Assurance Nurse (QA RN)) will conduct 2 months of 100% record review of all active charts, with an agency goal of 100% compliance with the maintenance of updated medication profiles in the patient's agency chart according to MD orders for the discontinuation of medications, dosage adjustments and initiation of new medications. 100 % audit will be ongoing until a 100% rate of compliance is achieved for 2 consecutive months; at such time auditing will be reduced to 50% of clinical records of active patients on a monthly basis with the goal of 100% rate of compliance. If this goal is not maintained, the agency will resume 100% audits until 2 consecutive months of compliance is achieved again. This will continue on an ongoing basis.*** In addition, if Amended XT	3/3/10 6/14/10 and ongoing

Noel Muntaj, BD 4/8/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620	Continued From page 7 effectiveness, med compliance.....". The record includes the nurse's visit notes dated 12/29/09 and 1/20/10. There is no documentation of a reason the patient was visited twice a month as per the Plan of Care. There is no documentation of the physician's order to change the Plan of Care and documentation that the nurse had consulted with the physician to change the visit frequency. During interview on 2/18/2010 with the DCS and Nursing Supervisors, the DCS stated that the insurance carrier would not approve the additional nursing visits. The agency did not provide additional information and/or documentation during the survey.	H 620	any clinician is found as a result of the audit to be deficient in the above noted documentation, he/she will be counseled regarding the necessity of updating and keeping current the medication profile in the patient's home and the patient's agency chart according to the MD orders for the discontinuation of medications, dosage adjustments and initiation of new medications. ***Measures or Systemic Changes to Prevent Recurrence:*** MCPs and Rehab Director or designee will include comprehensive review of medication profile in the home and clinical record during all supervisory home visits to ensure that the patient's medication profile both in the home and in the clinical record are updated to reflect all changes in the patient's medication regimen, including discontinuation of mediations, dosage adjustments. Any deficiencies that are found will be documented on the Supervisory and Competency Evaluation Form and reviewed with the clinician. (See attachment C.) ***Measures or Systemic Changes to Prevent Recurrence:*** In order to monitor compliance and prevent recurrence of this deficiency, the DCOS and QA will complete a 100% retrospective review of all patient charts upon discharge to ensure compliance. Counseling of clinician regarding the necessity of updating and keeping current the medication profile in the patient's home and the patient's agency chart according to the MD orders for the discontinuation of medications, dosage adjustments and initiation of new medications will be completed if any deficiency is identified. Amended 4/5	5/19/10 and ongoing. 5/19/10 and ongoing

Joel Muntaff, BO 4/5/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620		H 620	***QA Program to Monitor:*** ***Results of record audits will be presented to the Professional Advisory Committee (PAC) at PAC meetings and PAC input will be incorporated into the monitoring of records. PAC meeting minutes, including the reporting of the record audit results, will be sent to the Governing body.*** The DCOS will have overall responsibility to ensure that all corrective actions are completed.	6/01/10
		H 620	***Actions for Specific Patients Affected:*** The clinician for patient #2 was counseled by MCP on 2/22/10 regarding lack of notification of physician regarding deviation from ordered visit frequency on plan of treatment and of the necessity to document all consultations with physician regarding any changes to the ordered plan of treatment, including changes to the visit frequency. ***Measures or Systemic Changes to Prevent Recurrence:*** Mandatory meeting held on 3/3/10 for all clinicians. The Director of Clinical Operations and Services (DCOS) instructed all clinicians regarding the importance of notification of physician regarding deviation from ordered visit frequency on plan of treatment and of the necessity to document all consultations with physician regarding any changes to the ordered plan of treatment, including changes to the visit frequency. ***Please see Attachment D, sign-in sheet for Mandatory meeting of 3/3/10.***	2/22/10 3/3/10

Used Wintergreen, BD 4/8/10

9059

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620		H 620	***Actions for Patients Potentially Affected and QA Program to Monitor:***	
			To identify patients having the potential to be affected by the same deficiency, and to ensure that the deficient practice does not recur (QA Program), the DCOS and Quality Assurance Nurse (QA RN)) will conduct 2 months of 100% record review of all active charts, with an agency goal of 100% compliance with the plan of treatment in regards to visit frequency. 100 % audit will be ongoing until a 100% rate of compliance is achieved for 2 consecutive months; at such time auditing will be reduced to 50% of clinical records of active patients on a monthly basis with the goal of 100% rate of compliance. If this goal is not maintained, the agency will resume 100% audits until 2 consecutive months of compliance is achieved again. This will continue on an ongoing basis. In addition, if any clinician is found as a result of the audit to be deficient maintaining compliance with ordered frequency of visits as per plan of treatment, or in documentation of all consultations with physician regarding any changes to the ordered plan of treatment, including changes to visit frequency, will be counseled regarding the above noted issues.	***6/14/10 and ongoing***
			Measures or Systemic Changes to Prevent Recurrence::	
			In order to monitor compliance and prevent recurrence of this deficiency, the DCOS and QA RN will complete a 100% retrospective review of all patient charts upon discharge to ensure compliance. Counseling of clinician will be completed if any deficiency is identified.	5/19/10 and ongoing

Used Wintaff, BD 4/5/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0939C	A. BUILDING _____ B. WING _____	02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES - HAUPPAUGE	888 VETERANS MEMORIAL HIGHWAY, SUITE 210 HAUPPAUGE, NY 11788

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 620		H 620	*QA Program to Monitor:* *Results of record audits will be presented to the Professional Advisory Committee (PAC) at PAC meetings and PAC input will be incorporated into the monitoring of records. PAC meeting minutes, including the reporting of the record audit results, will be sent to the Governing body.* The DCOS will have overall responsibility to ensure that all corrective actions are completed. Accepted 4/12/2010 LCO 211 CRSC	6/1/10

Used Until 6/1/10 BD 4/8/10

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

March 26, 2010

Progressive Home Health Services, Inc.
Attn: Eleanor Halley
VP/Administrator
132 West 31st Street, 7th Floor
New York, NY 10001

Re: Response to Plan of Correction
License: 1348L001
Survey Date: 01/14/2010

Dear Ms. Halley:

Please be advised that the Plan of Correction relating to the recent Full Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 427-4921.

Sincerely,

C. Phoenix-Tannis, M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A full survey was conducted at Progressive Home Health Services Agency, Inc., 132 West 31st Street, 7th Floor, New York, New York on January 14, 2010. Twelve (12) personnel records were reviewed and are identified as Employee #1 to #12. Five (5) patient care records were reviewed and are identified as Patient #1 to #5. The Policy and Procedure Manual, Operating License, Complaint Log, Health Provider Network (HPN) Policy and Procedure, Criminal History Record Check, Emergency Preparedness and Quality Improvement meeting minutes were reviewed.	H 000	Please see attached transfer summaries (Attachments 1 and 2) These summaries were presented, reviewed and discussed by the President and the Director of Patient Services at the time of the survey.	
H 324	766.2(a)(9) Patient service policies and procedures 766.2 Patient service policies and procedures. (a) The governing authority shall ensure for each health care service provided that: (9) a patient is discharged by the agency after notification of the authorized practitioner, as defined in subdivision (b) of section 766.4 of this Part, and consultation with the patient and any other professional staff involved in coordinating the plan of care, no less than 48 hours prior to patient discharge. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to notify the physician within 48 hours prior to patient discharges. This was evident from two (2) out of five (5) patient care records reviewed (Patients #4 and 5).	H 324	Patient number 4 was transferred by the patient's family member and physician to a certified home health agency for skilled services not provided by Progressive Home Health Services. The physician initialed the care and transfer. A late note has been entered into the patient's chart clarifying this. Patient number 5 was transferred by his physician to an inpatient rehabilitation center. A late note clarifying this has been entered into his chart. Documentation for all patients who have impending discharges will be reviewed prior to discharge to insure that the physician is notified at least 48 hours prior to discharge. Responsibility: Director of Patient Services.	3/7/2010

Eleanor Haller

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ADMINISTRATOR

(X6) DATE: 3/17/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 324	Continued From page 1 Failure to ensure that the physician is notified within 48 hours of patient discharge places patients at risk for receiving poor discharge plans. The finding is: 1)Patient #4 has diagnoses of Colon Cancer, Dementia, Constipation, Hypertension; History of Breast Cancer; Transient Ischemic Attack, Depression. The patient care record contains a discharge summary dated 11/13/09 documents the physician was notified on "11/13/09". 2) Patient #5 has diagnoses of Alzheimer's Disease, Mitral Valve Replacement, Hypertension and Hypercholesterolemia. The patient care record contains a discharge summary dated 09/23/09 documents that the physician was on 09/23/09. On January 14, 2010, the President and Director of Patient Services were interviewed and did not give an explanation for the physician not being notified prior to discharge.	H 324	This page intentionally left blank.	
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional	H1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 2 persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure the Quality Improvement (QI) Committee meeting are attended by a physician and consumer. Failure to ensure the Quality Improvement Committee performs the required functions places patients at risk for receiving poor quality services, unsafe and inadequate care. The findings are:	H1036	This page intentionally left blank.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 3 The QI committee meeting minutes do not have documented evidence of physician and consumer attendance for the following meeting: February 1, 2007,August 2, 2007, May 3, 2007, May 1, 2008 and May 7, 2009. On January 14, 2010, the President and Director of Patient Services were interviewed and did not give an explanation for the physician and consumer not attending the meetings.	H1036	The QI Committee attendance sheets provided to the surveyors are attached (Attachments 3a-e) These attendance sheets were presented to the surveyors by the President and the Director of Patient Services, and were reviewed and discussed at length during the closing conference.	
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to	H1142	Progressive has a physician, as a member of the QI Committee although a physician is not required by regulation since Progressive does not provide "professional health care services." (The physician was in fact present at each meeting of the QI Committee.) Progressive Home Health Services is conducting a search for an alternate consumer member who will be assigned when the primary consumer member is unable to attend the QI meeting. Responsibility: Director of Patient Services Expected date of completion: May 6, 2010 (next QI meeting)	5/6/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 4 requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on observation and staff interview, the agency did not maintain a complete and current Health Provider Network (HPN) Communications Directory. Failure to maintain a complete and current HPN Communications Directory places patients at risk for unsafe care during an emergent situation. The finding is: On January 14, 2010, the Administrator logged onto the agency HPN Communications Directory and printed out a copy of the "Select a Role to Assign/Modify for Progressive Home Health Services, Inc." from HPN. There is no documentation of the contact names for the following roles: Order Official Prescriptions, Governing Body Chairman/President, Infection Control Practitioner. On January 14, 2010, the President and Director of Patient Services were interviewed and did not	H1142	The President and the Director of Patient Services discussed during the closing conference of 1/14/10 survey the process for monthly review of the HPN Communications directory. All appropriate roles have been assigned in the HPN. The HPN Coordinator will review the HPN website during the first week of every month to assure that all roles remain current and the 20 available user slots are being utilized by Progressive Home Health Services to satisfy regulatory requirements. The HPN Coordinator will document that the task has been completed via an email sent to the Director of Patient Services. Responsibility: HPN Coordinator	1/14/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 5 give an explanation for the finding.	H1142	This page intentionally left blank.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0691C	A. BUILDING _____ B. WING _____	01/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOME HEALTH SERVICES AG	132 WEST 31ST STREET, 7TH FLOOR NEW YORK, NY 10001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 722	402.6(d) Criminal History Record Check Process Section 402.6 Criminal History Record Check Process. (d) A provider may temporarily approve a prospective employee while the results of the criminal history record check are pending. The provider shall implement the supervision requirements identified in section 402.4 of this Part, applicable to the provider, during the period of temporary employment. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not document weekly supervision for all employees required for Criminal History Record Check (CHRC). This was evident for two (2) of twelve (12) personnel records reviewed (Employees #4 and 7). Failure to document weekly supervision while awaiting the results of the CHRC places patients at risk for receiving unsafe care. The findings are: 1) Employee #4 is a Home Health Aide hired by the agency on "12/5/06". 2) Employee #7 is a Home Health Aide hired by the agency on "5/12/07". There is no documented evidence of weekly supervision of Employee #4 between 02/11/07 and 03/23/07 while awaiting the results of the criminal history record check until the CHRC results returned. There is no documented evidence of weekly supervision of Employee #7 between 06/01/07 and 08/17/07 while awaiting the results of the	R 722	Employee # 4 was hired on 12/5/06 and the fingerprint results were not received until 3/23/07 and Progressive was unable to locate/produce documented supervision after 2/11/07. Employee # 7 was hired on 5/12/07 and the fingerprint results were not returned until 8/17/07 and Progressive was unable to locate/produce documented supervision after 6/1/07. (The challenge the agency faced was the projected DOH CHRC turnaround time (7-10 business days – see attachment # 4) when the reality for both DOH CHRC and the agency was a 45+ day turnaround.) In 2008 after a self-audit of our CHRC Supervision processes, procedures and staffing resources adjustments were made to assure consistent supervision including assigning a full-time dedicated staff member to oversee all aspects of the agency's CHRC process/tracking. In addition, since the implementation in 2009 of Live Scan none of our active Aides have pending CHRC results. Responsibility: Administrator	6/20/2008

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

March 26, 2010

Premier Home Health Care Services, Inc.
Attn: Donna Duggin, RN
Director of Clinical Services
42 Broadway, 21st Floor
New York, NY 10004

Re: Response to Plan of Correction
License: #1086L005
Survey Date: 2/9/10

Dear Ms. Duggin:

Please be advised that the Plan of Correction relating to the recent State Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 417-4921.

Sincerely,

C. Phoenix-Tannis, M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

PREMIER
home health care services, inc.

March 16, 2010

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Office
90 Church Street
New York, New York 10007

RE: Premier Home Health Care Services, Inc. – Manhattan
License: 1086L005
Survey Date: February 9, 2010

Dear Ms. Phoenix-Tannis,

Attached, please find our plan of correction with the supporting documentation for the survey conducted on the above date.

The person responsible for overseeing the plan of correction will be Marcos Maltez, Regional Vice President.

If you have any questions, please feel free to contact me at 914 467-5567.

Sincerely,

Donna Duggan, RN
Director of Clinical Services

RECEIVED
MAR 17 2010

445 Hamilton Avenue, 10th Floor, White Plains, New York 10601 Phone 914-428-7722 Fax 914-428-2404

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State re-licensure survey was conducted at Premier Home Health Care Services, Inc. on February 9, 2010. Six (6) Patient Care Records were reviewed and are identified as Patients #1 to 6. Eight (8) Patient Care Records with incidents were reviewed and are identified as Patients #7 to 14. Seven (7) Personnel Records were reviewed and identified as Employees #1 to 7. Five (5) of the seven (7) personnel records reviewed are Home Health Aides. The agency Policy and Procedure Manual, Quality Improvement Committee Meeting Minutes, Complaint Log and Admission Packet were reviewed. The agency Director of Patient Services (DPS) was off-site at the corporate office and was interviewed via telephone conference. The Regional Vice President of Operations, the Office Administrator and the Human Resources Manager were present on-site during the survey and during the telephone conference with the DPS.	H 000		
H 204	766.1(a)(1) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to:	H 204	**I. Corrective action for those patients found to be affected by the deficient practice:** **The Field Nurse Supervisor and Office Administrator will audit all applicable client service agreements and reissue the new client service agreement on their next visit.**	5/31/10

Donna Duff, RN Director of Clinical Services
L ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 3/16/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 1 (1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record; (2) be given a statement of the services available by the agency and related charges; (3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient. (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change. (ii) All information required by this paragraph shall be provided to the patient both orally and in writing; (4) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services. This Regulation is not met as evidenced by: Based on record reviews and staff interviews, the agency did not provide patients with complete information regarding the frequency of aide services and financial responsibility. This was evident for four (4) of six (6) patient care records reviewed (Patients #2, 3, 5 and 6). Failure to provide patients with complete information regarding the frequency of aide	H 204	II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed cases have the potential to be affected by this deficient practice. 1. As of 2/09/10, there are a total of 150 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. The Client Service Agreement has been revised to reflect these changes. III. Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. FNS's were educated on the new Client Service Agreement. 2. The new Client Service Agreement will be included in the RN orientation for all new hires. 3. The Regional Director of Patient Services will be responsible for overseeing the audit process and then the Office Administrator moving forward. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? As is company practice, random quarterly chart audits will continue to ensure compliance with new Client Service Agreement. 1. As of 2/9/10 there are a total of 150 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 204	Continued From page 2 services and financial responsibility places patients at risk for receiving poor care as a result of not having all needs met. The findings are: 1) The agency "Client Service Agreement" lacks documentation of the rate per hour or day for Home Health Aide services. 2) The agency "Client Service Agreement lacks documentation of the frequency and rate for Home Health Aide services. The "Plan of Care" reviewed by the agency nurse on "10/5/09" lacks documented evidence of the patient's signature. 3) The patient care record lacks documentation of an agency "Client Service Agreement" form. 4) The agency "Client Service Agreement" form lacks documentation of the services to be provided. On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President of Operations were interviewed and did not provide an explanation.	H 204	2. Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	
H 224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to:	H 224	I. Corrective action for those patients found to be affected by the deficient practice: All case managed cases will be re-issued the updated Complaint/Occurrence Reporting Form including the appeal process.	5/31/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 3 (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not provide patients the time frame in which the agency must respond to an appeal. This was evident for the agency admission packet. Failure to document complete complaint information places patients at risk for not being able to fully exercise their right to make a complaint. The finding is: The agency "Patient Bill of Rights" found in the admission packet lacks documented evidence informing patients of the right to appeal the agency's decision about a complaint and the agency has thirty (30) day within which to respond to an appeal. On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President of Operations were interviewed and did not provide an explanation.	H 224	**II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed cases have the potential to be affected by this deficient practice.** **1. All clients will be issued new "Complaint/Occurrence Procedure" that includes the time frame for appeal on their next scheduled visit.** **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **1. All case managed cases will be re-issued the updated Complaint/Occurrence Reporting Form including the appeal process.** **2. The RN orientation will be updated to reflect this form revision for all new hires.** **3. The Office Administrator and Regional Director of Patient Services will perform weekly audits of the admission package compliance.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **1. The Office Administrator and Regional Director of Patient Services will perform weekly audits of the admission package compliance.** **2. FNS/DPS will review client forms during home visits.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 4	H 514		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to ensure medical orders are complete and signed within 30 days by an authorized practitioner. This was evident for six (6) of six (6) patient care records reviewed (Patients #1, 2, 3, 4, 5 and 6). Failure to ensure medical orders are complete and signed within 30 days places patients at risk for unsafe and unauthorized care. The findings are : 1) Patient #1 has diagnoses which include: Non-Insulin Dependent Diabetes Mellitus, Depression, Hyperlipidemia and Osteoporosis. The medical order "12/7/09 to 6/7/10" lacks documented evidence of the specific type of aide services. The patient care record includes an "Addendum	H 514	1. Corrective action for those patients found to be affected by the deficient practice: 1. Patient #1 – FNS was re-educated on appropriate identification of type of service. Circle HHA/PCA to indicate service. (Patient #1, #4, #5, #6) FNS wrote a plan of correction on the addendum as a result of an in-house audit which identified missed diagnosis's for medications listed on the plan of treatment dated 6/6/09-12/6/09. Plan of Treatment re-faxed to MD for signature that declined to sign out-dated order.	2/23/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 5 to Plan of Treatment" initiated by the agency nurse on "11/16/09". There is no documented evidence of a physician's signature. The patient care record documents an order for "Ativan 1 mg" initiated by the agency nurse on "5/29/09" and signed "7/23/09" past thirty (30) days by the physician. The medical order dated "6/5/08 to 12/5/08" and the addendum to the medical order lack documented evidence of a physician's signature. 2) Patient #2 has diagnoses which include: Cardiac Disease and Dementia. The medical order "1/7/2010 to 7/7/2010" documents the patient is ordered the medication "Coumadin". There is no corresponding diagnosis for this medication. The medical order lacks documented evidence of the specific type of aide services. 3) Patient #3 has diagnoses which include: Insulin Dependent Diabetes Mellitus, Hypertension, Legal Blindness and Right Below the Knee Amputation. The "Physicians Plan of Treatment" dated "4/6/09 to 10/6/09" and initiated by the nurse on "4/6/09" documents the physician signed the order past thirty (30) days on "7/3/09". 4) Patient #4 has diagnoses which include: Insulin Dependent Diabetes Mellitus, Hypertension, Epilepsy and Glaucoma. The "Physicians Plan of Treatment" dated "7/16/09 to 1/16/2010" documents the agency nurse initiated the "Plan of Treatment" on	H 514	2. Patient #2 - FNS was re-educated on completion of plan of treatment. Patient was on Coumadin for diagnoses of Atrial Fibrillation which was omitted from the plan of treatment. Patient #4 – FNS omitted diagnosis's on plan of treatment for medication Flomax, Synthroid and Fosamax. Addendum to plan of treatment sent to physician. 3. FNS was re-educated on the regulations and agency policy and procedure for obtaining signed MD orders within 30 days (Patient #1, #3, #4, & #6). II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed cases have the potential to be affected by this deficient practice. As of 2/09/10, there are a total of 150 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. III. Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. The Regional Director of Patient Services will be responsible for overseeing the audit process and then the Office Administrator moving forward. 2. FNS's re-educated on completion of POT inclusive of identification of services provided, diagnoses matching medications, obtaining signed MD orders within 30 days as per agency policy and state regulation.	5/31/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 6 "7/28/09" and the physician signed the order past thirty (30) days on "11/16/09". The "Physicians Plan of Treatment" dated "1/16/2010 and 7/16/2010" documents the patient is ordered the medications "Flomax, Synthroid, and Fosamax". There are no corresponding diagnoses for these medications. The medical order lacks documented evidence of the specific type of aide services. 5) Patient #5 has diagnoses which include: Non-Insulin Dependent Diabetes Mellitus, Arthritis and Hypertension. The "Physicians Plan of Treatment" dated "9/10/09 to 3/10/10" lacks documented evidence of the specific type of aide services. 6) Patient #6 has diagnoses which include: "Glaucoma and Anxiety Disorder". The "Physician Plan of Treatment" dated "1/19/10 to 7/19/10" lacks documented evidence of the specific type of aide services. On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President of Operations were interviewed and did not provide an explanation.	H 514	IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? As is company practice, random quarterly chart audits will continue to ensure compliance with completion of plan of treatment and MD signature within 30 days. 1. As of 2/9/10 there are a total of 150 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	
H 708	766.6(a)(3) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (3) nursing assessments conducted to provide	H 708	1. Corrective action for those patients found to be affected by the deficient practice: Case managed patients assigned to same FNS were affected by this deficient practice.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 708	Continued From page 7 services. This Regulation is not met as evidenced by: Based on record reviews and staff interviews, the agency failed to document nursing assessments. This was evident for two (2) of six (6) patient care records reviewed (Patients #1 and 3). Failure to document nursing assessments places patients at risk for receiving poor quality of care. The findings are: 1) Patient #1 has diagnoses which include: Non-Insulin Dependent Diabetes Mellitus, Depression, Hyperlipidemia and Osteoporosis. The "Physician Plan of Treatment" dated "12/5/08 to 6/5/09" documents nursing visits "every 30 to 90 days". The "Physician Plan of Treatment" dated "6/6/09 to 12/6/09" documents nursing visits every 60 to 90 days". There is no documented evidence of nursing assessments completed 30, 60 or 90 days between nursing assessments "5/29/09" and "11/9/09". 2) Patient #3 has diagnoses which include: Insulin Dependent Diabetes Mellitus, Hypertension, Legal Blindness and Right Below the Knee Amputation. The "Physician Plan of Treatment" dated "4/6/09 to 10/6/09" documents nursing visits "every 60 to 90 days". There is no documented evidence of a nursing assessment done 60 or 90 days between nursing assessments dated "6/29/09" and "10/5/09" for Patient #3.	H 708	1. Patient's #1 & #3, Initial assessments were completed. Both assessments were removed in error when chart was divided. They have now been filed correctly in clinical record. 2. FNS for patient's #1 & #3 from the period of 6/6/09-12/6/09 has been terminated from the agency and is unavailable to provide documentation. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed cases have the potential to be affected by this deficient practice. 1. As of 2/09/10, there are a total of 150 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. All case managed cases assigned to terminated FNS were reassigned at that time and visits are being done every 60 days as per agency policy. III: Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. The Regional Director of Patient Services will be responsible for overseeing the audit process and then the Office Administrator moving forward. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? As is company practice, random quarterly chart audits will continue to ensure compliance with visit frequency and submission of documentation.	5/30/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 708	Continued From page 8 On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President of Operations were interviewed and did not provide an explanation.	H 708	1. As of 2/9/10 there are a total of 150 case managed cases. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	
H 714	766.6(a)(6) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (6) supervisory reports of the registered professional nurse, licensed practical nurse or the therapist, if applicable, of the home health aide or personal care aide. This Regulation is not met as evidenced by: Based on record reviews and staff interviews, the agency failed to include aide supervisory reports in patient care records. This was evident for three (3) of six (6) patient care records reviewed (Patients #1, 3 and 6). Failure to include supervisory aide reports places patients at risk for receiving unsafe and poor care from potentially unqualified employees. The findings are: 1) The patient care records for Patients #1 and 3 lack documented evidence of aide supervisory reports. 2) The patient care record for Patient #6 documents one (1) aide supervision report. On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President	H 714	I. Corrective action for those patients found to be affected by the deficient practice: FNS was re-educated on agency policy regarding HHA supervisory documentation on every visit. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed patients have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From page 9 of Operations were interviewed and did not provide an explanation. During the exit interview on February 9, 2010, the Vice President of Operations stated: "All our aides are not supervised on each case we keep the supervision reports in the aide's record."	H 714	1. The agency will perform 100% audit of the balance of the current population of case managed cases. The Regional Director of Patient Services will be responsible for overseeing the audit process and then the Office Administrator moving forward.	
H1010	766.9(e) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (e) make available to the public information concerning the services which it offers, the geographic area in which these services are made available, the charges for the various types of service and the payment mechanisms which may be available for such services. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency did not provide the public correct information about the available services and correct agency contact information. This was evident for the agency admission packet. Failure to to provide the public with correct information places patients at risk for receiving poor care as a result of receiving unauthorized care and not being able to contact the agency. The findings are: 1) The agency brochure found in the admission packet documents the agency provides: "Certified Nursing Assistants, Hospice Programs and Hospice Care".	H1010	III. Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. FNS's were re-educated on agency policy and documentation regarding HHA supervision. 3. As is company practice all new RN's will continue to be oriented to the policy regarding documentation of HHA supervision. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? As is company practice, random quarterly chart audits will continue to ensure compliance with documentation of HHA supervisory visits. 1. The agency will perform 100% audit of the balance of the current population of case managed cases. 2. Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From page 9 of Operations were interviewed and did not provide an explanation. During the exit interview on February 9, 2010, the Vice President of Operations stated: "All our aides are not supervised on each case we keep the supervision reports in the aide's record."	H 714	**Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.**	
H1010	766.9(e) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (e) make available to the public information concerning the services which it offers, the geographic area in which these services are made available, the charges for the various types of service and the payment mechanisms which may be available for such services. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency did not provide the public correct information about the available services and correct agency contact information. This was evident for the agency admission packet. Failure to to provide the public with correct information places patients at risk for receiving poor care as a result of receiving unauthorized care and not being able to contact the agency. The findings are: 1) The agency brochure found in the admission packet documents the agency provides: "Certified Nursing Assistants, Hospice Programs and Hospice Care".	H1010		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 714	Continued From page 9 of Operations were interviewed and did not provide an explanation. During the exit interview on February 9, 2010, the Vice President of Operations stated: "All our aides are not supervised on each case we keep the supervision reports in the aide's record."	H 714		
H1010	766.9(e) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (e) make available to the public information concerning the services which it offers, the geographic area in which these services are made available, the charges for the various types of service and the payment mechanisms which may be available for such services. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency did not provide the public correct information about the available services and correct agency contact information. This was evident for the agency admission packet. Failure to to provide the public with correct information places patients at risk for receiving poor care as a result of receiving unauthorized care and not being able to contact the agency. The findings are: 1) The agency brochure found in the admission packet documents the agency provides: "Certified Nursing Assistants, Hospice Programs and Hospice Care".	H1010	I. Corrective action for those patients found to be affected by the deficient practice: 1. Brochures issued by agency in admission package are in the process of being revised. 2. While agency brochure is under revision, all patients well be issued an interim form explaining services provided at branch. 3. Admission packages will be corrected with labels reflecting branch address and telephone number. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed patients have the potential to be affected by this deficient practice. 1. Brochures issued by agency in admission package are in the process of being revised. 2. While agency brochure is under revision, all patients well be issued an interim form explaining services provided at branch. 3. Admission packages will be corrected with labels reflecting branch address and telephone number.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1010	Continued From page 10 Licensed Home Care Service Agencies cannot hire Certified Nursing Assistants and cannot provide Hospice Programs/Care. 2) The agency brochure and back cover of the admission packet documents the agency's White Plains address and telephone number. The agency is located in New York City. On February 9, 2010 at 3:50 PM, the Director of Patient Services and the Regional Vice President of Operations was interviewed and did not provide an explanation.	H1010	3. As is agency practice, all employees will be educated on new brochure and services provided at time of issuance. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? Based on the structure established by the governing authority, the agencies new brochure will be reviewed at the Branch/Regional and Corporate QI quarterly meetings and reflected in the minutes.	6/30/10
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:	H1036	I. Corrective action for those patients found to be affected by the deficient practice: There were no patient's found to be affected by this regulation. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: 1. In the QI meeting minutes of 3/26/08, it was identified by the new VP of Clinical Services that a Consumer Representative was required. 2. A Consumer representative was appointed in 2008 and remains active on the committee.	CORRECTED 2008

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 11 (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the Governing Authority failed to ensure the Quality Improvement (QI) Committee performs the required functions. This was evident for the agency Quality Improvement Committee meeting minutes. Failure to ensure the Quality Improvement Committee performs the required functions places patients at risk for receiving poor quality services, unsafe and inadequate care. The findings are: The QI meetings dated "3/26/08" and "6/21/07" lack documented evidence of consumer attendance. During the exit interview on February 9, 2010, the Vice President of Regional Operations was interviewed and did not provide an explanation.	H1036	III. Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. The QI Committee structure will continue to meet quarterly and minutes will reflect attendees. 2. The VP of Clinical Services will continue to monitor that all required attendees are active participants and in the event that committee members terminate membership, the alternates will be acquired. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? Based on the structure established by the governing authority, the committee structure will remain in effect at the branch, regional, regional and corporate level with quarterly meetings.	
H1302	766.11(a) Personnel 766.11 Personnel.	H1302		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1302	Continued From page 12 The governing authority or operator shall ensure for all health care personnel: (a) the development and implementation of written personnel policies and procedures, which are reviewed at least annually and revised as necessary. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not review and revise personnel policies and procedures. This was evident for the agency policy and procedure manual. Failure to review and revise personnel policies and procedures places patients at risk for receiving poor quality of care that is not according to current regulations. The findings are: 1) There is no documented evidence of a Home Care Registry Policy and Procedure. 2) The agency "Complaint/Grievance Process" lacks documented evidence of the Department of Health telephone number and address for complaints. On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President of Operations were interviewed and did not provide an explanation.	H1302	I. Corrective action for those patients found to be affected by the deficient practice: 1. The Home Care Registry was implemented on 9/25/09 as per SDOH regulation. 2. The policy and procedure has been written to reflect that process. 3. The "Patient Bill of Right" includes the SDOH Telephone #. 4. The "Complaint/Occurrence" form in the admission package is blank until admission and completed by FNS in the client's home. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed cases have the potential to be affected by this deficient practice. 1. All agency staff will be educated on the agency policy and SDOH regulation regarding the Home Care Registry. 2. The agency will perform 100% audit of the all new trainee's to ensure adherence to agency policy and procedure and SDOH regulations. 3. The Office Administrator and Director of Clinical Services will oversee the auditing process. III. Measures that will be put in place to ensure that the deficient practice will not reoccur: All patients are affected by this deficient practice.	
H1338	766.11(g) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel:	H1338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1302	Continued From page 12 The governing authority or operator shall ensure for all health care personnel: (a) the development and implementation of written personnel policies and procedures, which are reviewed at least annually and revised as necessary. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not review and revise personnel policies and procedures. This was evident for the agency policy and procedure manual. Failure to review and revise personnel policies and procedures places patients at risk for receiving poor quality of care that is not according to current regulations. The findings are: 1) There is no documented evidence of a Home Care Registry Policy and Procedure. 2) The agency "Complaint/Grievance Process" lacks documented evidence of the Department of Health telephone number and address for complaints. On February 9, 2010 at 3: 50 PM, the Director of Patient Services and the Regional Vice President of Operations were interviewed and did not provide an explanation.	H1302	1. All agency staff will be educated on the agency policy and SDOH regulation regarding the Home Care Registry. 2. The agency will perform 100% audit of the all new trainee's to ensure adherence to agency policy and procedure and SDOHH regulations. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? 1. The agency will perform 100% audit of the all new trainee's to ensure adherence to agency policy and procedure and SDOH regulations. 2. Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	5/31/10
H1338	766.11(g) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel:	H1338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1338	Continued From page 13 (g) that personnel records include verifications of employment history and qualifications for the duties assigned and, as appropriate, signed and dated applications for employment; records of professional licenses and registrations; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessment shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given patient medical records under section 766.6 of this Part. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not maintain complete personnel records for employees. This was evident for five (5) of seven (7) personnel records reviewed (Employees #1, 2, 4, 6 and 7). Failure to maintain complete personnel records for employees places patients at risk for receiving poor quality of care from potentially unqualified personnel. The findings are: 1) Employee #1 is a Home Health Aide hired by the agency on "7/24/08". There is no documented evidence of Criminal History Record Check (CHRC) weekly supervision from "7/24/08" until the CHRC results returned "8/29/08".	H1338	I. Corrective action for those patients found to be affected by the deficient practice: 1. Employee #1 – Employee did not begin work until 7/31/08, Phone call made 8/1/08. Only one call was made because the employee did not work again until 9/8/08. The CHRC was returned on 8/29/08. 2. Employee #2 – work reference verified 2/10/10. 3. Employee #4 – work reference verified 2/10/10. 90-day evaluation was done 11/28/08; Administrative evaluation was done 3/23/09. 4. The agency maintains personnel records for Clinical Field Admin. staff in corporate office. Personnel records are available upon request. 5. Employee #6 - Health Assessments for 2007 & 2008, Drug screen 2007, Hepatitis B declination, Rubeola/Rubella 2008, Annual TB questionnaire 2008, HIV confidentiality 1/6/99, RN orientation 6. Employee #7 – verified references, Annual Health Assessment 2007, TB Questionnaire 2007, 2008, 2009, Rubeola/Rubella 2008, Drug screen 2007, Annual Mandatories 2007, and HIV Confidentiality 2007 II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All patients have the potential to be affected by this deficient practice.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1338	Continued From page 14 2) Employee #2 is a Home Health Aide hired by the agency on "12/26/08". The personnel record documents evidence of previous work experience. There is no documented evidence of references from previous employers.. 3) Employee #4 is Home Health Aide hired by the agency on "9/3/08". The personnel record documents evidence of previous work experience. There is no documented evidence of references from previous employers. There is no documented evidence of an annual evaluation from the time of hire "9/3/08 to 10/3/09". 4) The agency does not maintain complete personnel records of the Registered Nurses (Employees # 6 and 7) on-site. The complete personnel records for are kept at the agency's corporate office. 5) Employee #6 is a Registered Nurse hired by the agency on "12/1/07". The personnel record provided did not include the following information: verified references; annual health assessment for the years 2007 and 2008; annual Mantoux/PPD testing results; orientation to policy and procedures and emergency disaster plan; and annual HIV Confidentiality and Universal Precautions training. 6) Employee #7 is a Registered Nurse hired by the agency on "2/23/04". The personnel record did not include the following information: annual health assessments for the	H1338	1. As is agency practice, quarterly audits will be done on 10% of employee records. 2. The audit process will be completed by the Compliance Coordinator and overseen by the Office Administrator. 3. Audit results will be reported at the Branch, Regional and Corporate QI Committee meetings. III. Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. As is agency practice, quarterly audits will be done on 10% of employee records. 2. The audit process will be completed by the Compliance Coordinator and overseen by the Office Administrator. 3. Audit results will be reported at the Branch, Regional and Corporate QI Committee meetings. IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? 1. As is company practice, random monthly chart audits will continue to ensure compliance with this regulation. 2. Audits will be conducted by the compliance coordinator and overseen by the Office Administrator.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0585C	A. BUILDING _____ B. WING _____	02/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	42 BROADWAY, 21ST FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1338	Continued From page 15 years 2007 and 2008; and annual HIV Confidentiality and Universal Precautions training for the years 2007 and 2008. On February 9, 2010 at 4:20 PM, the Regional Vice President of Operations and the Human Resources Supervisor were interviewed and did not provide an explanation for Employees #1. 2 and 4. The Regional Vice President of Operations stated for Employees #6 and 7: "I am sure all of these are at the corporate office and can be scanned to us."	H1338	**3. Based on the structure established by the governing autbority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.**	5/31/10

PRINTED: 04/13/2010
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0908D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSC	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A Re-Licensure Survey was conducted at All Metro Health Care on March 31 and April 1, 2010. Seven (7) patient care records were reviewed and identified as Patients #1 - #7. Two (2) home visits were made to Patients #1 and #7. Nine (9) personnel records were reviewed and identified as Employees #1 - #9. The agency's Complaint Log, Quality Improvement meeting minutes, the Health Provider Network Policy and Procedure, the Criminal History Record Check Policy and Procedure, On-Call Policy and Procedure, the Emergency Preparedness Plan and the Statistical Reports were reviewed.	H 000		
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal.	H 222		

SR

Office of Health Systems Management / Office of Long Term Care

Catherine M. Kelly Sr VP of Patient Services TITLE 4/28/10 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 06/15/2010
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0908D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSO	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From page 1 This Regulation is not met as evidenced by: Based on observation ,record review and staff interview, the Governing Authority (GA) failed to provide the patient with correct New York State Department of Health (NYS DOH) telephone number to ensure the patients' right to voice patient complaints and recommend changes in policies to the agency staff. This was evident in two (2) of two (2) home visits. (Patients #1 and #7) Failure to provide each patient with the correct NYS DOH telephone number places the patients at risk for not able to exercise all their rights. The findings are: 1) The Patient Rights and Responsibilities in the Admission Package, revised 5/08 under "ZZ" documents the use of a toll free hotline telephone number, the hours of operation, in order to obtain information about home health agencies. The "Toll-free Telephone Number" is handwritten as "1 800 220 - 7184" and in addition the agency provides an incorrect New Rochelle telephone numbers, which was also handwritten as "(914) 654 - 7121, 7122, 7131", for lodging patient complaints. The 1 - 800 220 - 7184, number when dialed has a recording which states: "Welcome to AT & T". 2) A home visit was made to Patient #1 on 3/31/10. The patient binder observed in the home lacks Patient Rights and Responsibilities with the NYSDOH telephone number to register complaints. During the visit, the Director of Clinical Services	H 222	**766.1(a)(8) Patient Rights** It is All Metro Health Care's policy that all patients receive the Patients' Rights and Responsibilities at the start of care, to include the NYS DOH Complaint Hotline #. The branch had the wrong telephone number of some of the forms. The correct number (212-417-5888) has been obtained and a stamp will be purchased so that each form can be stamped with the Hotline #. A new Bill of Rights has been sent to all current patients with a cover letter explaining the new Hotline number. Any old copies with the incorrect number will be discarded and field nurses will be instructed to discard any incorrect copies they may have. Admission packets shall be reviewed during routine, biannual internal audits conducted by the Office of the VP of Patient Services. Compliance is to be maintained at 90%. **Responsible Individual – DCS and VP of Patient Services** **Completion Date – May 31, 2010** Accepted 4/30/10 SR	

PRINTED: 04/13/2010
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LG6666D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSON	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From page 2 (DCS) was informed of the findings, the DCS stated "we will provide the patient with another copy". 3) A home visit was made to Patient #7 on 4/01/10. The patient Admission Package includes the Patient Rights and Responsibilities which lacks documentation of the NYSDOH telephone number to enable the patient to contact the NYSDOH to lodge a complaint. On 4/01/10, the DCS was informed of the survey findings, the DCS stated "I found the copy of the Patient Rights and Responsibilities with the correct NYSDOH telephone number".	H 222	H-408 766.3(d) Plan of Care It is All Metro Health Care's policy that all service orders other than 24 hour must-cover orders be written with an acceptable range of hours/days of service, validated by the MD. When a shift is uncovered, the patient/family is to be notified and a note is to be written in the ProHealth system explaining the gap in service. If this is a recurring event, the MD is to be notified and the aide(s)/nurse(s) are to be replaced. If this does not solve the problem, the open hours are to be called out to another agency for coverage. ProHealth notes are to be checked daily by the DCS and if such a problem is identified, the above noted process shall be put in place to remedy the situation. Aide time sheets are verified weekly against the schedule as part of the payroll process, and the Payroll Coordinator is to be instructed that gaps are to be immediately reported to the Branch Manager and DCS. An audit of all case managed cases is to be completed for the previous and upcoming month by May 31, 2010. to identify coverage issues and make necessary corrections. All associate staff are to be reoriented to All Metro's policy regarding notifying the patient/family of open shifts and documenting same in the system. SR	
H 408	766.3(d) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that (d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months; (1) each review shall be documented in the clinical record; and (2) agency professional personnel shall promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to alter the plan of care. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure that the Plans of Care were revised as needed in two (2) of seven (7)			

FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0WWD	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSON	1010 ROUTE 112 PORT JEFFERSON STATION, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From page 3 patient care records reviewed. (Patients #2, and #7) Failure to ensure that the Plans of Care are revised/updated as needed places the agency patients at risk for poor patient outcomes. The findings are: 1) Patient #2 has admission date of 9/15/09 with diagnoses of Dementia, Depressive Disorder and Hypertension. The Plan of Care dated 9/15/09 - 3/15/10 documents an order for Personal Care Aide (PCA) 4 - 6 hours/day x 4 - 5 x week. The patient care record documents that on 10/04/09, the nurse obtained a telephone orders to increase PCA service to 4- 6 hours/day x 5 - 7 x week The Plan of Care dated 3/15/10 - 9/15/10 lacks documentation to reflects increase in PCA hours and days of service. The "Aide Duty Sheets/Employee Time Sheets" continued to document that the patient was receiving PCA service from 2.5 hours a day to 6.5 hours a day 6 - 7 x week. 2) Patient #7 has an admission dated of 1/22/09 with a diagnosis of Alzheimer's Disease. The Plan of Care dated 7/22/09 - 1/22/10 and 1/22/10 - 7/22/10 documents an order for PCA 1 x week for bath visit. The patient care record documents that on 8/31/09, the nurse obtained a telephone orders to	H408	H408 Continued... A memo is to be sent to all nursing supervisors to remind them of the requirement for them to check the aide care plan against the time sheet to assure that the aides are addressing all requirements on the care plan and that they are not documenting care that *is not* on the care plan. Additionally they will be sent a copy of the job description for a HHA and a PCA for their reference when completing Aide Care Plans. If the care of the patient calls for tasks above the level of the service authorized, the office will be notified immediately so that a discussion can be had with the patient and family regarding how to meet the patient's needs while adhering to regulatory requirements. All HHA's will be sent a copy of the HHA and PCA Job Description with a reminder that they must follow the PCA Job Description when working on a PCA level case. All case managed files are to be reviewed by the DCS to assure that POC's are congruent with Med Profiles and Med Admin Records. Nursing and aide notes are to be reviewed weekly to assure that they are compliant with MD orders. Any variances are to be addressed and corrected immediately and unclear/incomplete orders are to be clarified with the MD and rewritten accordingly. All medications are to be reviewed by an RN during recertification visits, with POC's/Medication Profiles updated as needed. Orders for treatments and DME are to be clearly written indicating frequency and any other pertinent details. If the aide is to be applying braces or any other device, he/she is to be trained to do so by an RN, the training shall be documented, and the procedure is to be clearly outlined on the Aide Care Plan. If a HHA is to perform exercises written by a Therapist, a copy of these exercises shall be in the patient's chart and an order for same shall be validated by an MD. SR	

FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC06650	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSON	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 408	Continued From page 4 change PCA service bath visit 1-2 x week. The Plan of Care dated 1/22/10 - 7/22/10 lacks documentation to reflects change in PCA service. The "Aide Duty Sheets/Employee Time Sheets" weeks dated 1/03/10, 1/10/10, 1/17/10, 1/24/10, 2/07/10, 2/14/10, 2/21/10, 3/07/10, 3/14/10, and week of 3/21/10 continued to document that the patient was receiving PCA service 2 x week for bath. During an interview with the Director of Clinical Services (DCS) on 3/31/10 at 2:30 PM and was given an opportunity to provide an explanation. On 4/01/10, the DCS confirmed that the Plans of Care were not revised to reflect the changes.		**H408 Continued...** All field staff, including nurses, are to be sent a memo reminding them that they must notify the office immediately of any changes in the patient's status, treatment protocol or medications so that the orders and care plans may be updated accordingly and the changes noted in ProHealth. Interim Orders are to be tracked on the Physicians' Order Log along with all other MD orders. Nursing Supervisors are to review the home chart for all skilled cases during each visit to determine that the MAR's and treatments records are compliant with orders. If a parent is administering a medication, this shall be indicated on the MAR so that all doses are accounted for. This shall be monitored during routine, biannual internal audits conducted by the Office of the VP of Patient Services. Compliance is to be maintained at 90%. **Responsible Individual – DCS and VP of Patient Services** **Completion Date – May 31, 2010** Attachment received. TIC to DCS on 4/30/10 The DCS stated that the agency conducts QI audits quarterly. Accepted 4/30/10 SR	
H1014	768.9(g) Governing authority Section 768.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (g) employ or contract for a sufficient number of staff to coordinate, direct and deliver services to patients accepted for care in accordance with prevailing standards of professional practice. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to employ or contract for sufficient staff to ensure the delivery of Medical Social Work (MSW). This was evident for the agency's license. Failure to employ or contract staff to provide the services on the license places the patients at risk for not having social service needs met.			

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: LC0908D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSO	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1014	Continued From page 5 The finding is: The agency license included MSW as a service that the agency is able to provide. Upon request, the agency did not provide a contract for MSW services. On 4/01/10, the Director of Clinical Services (DCS) was interviewed and stated that the agency does not have a contract to provide MSW services and "the person who generates the contract is on vacation this week." H1020 766.9(j) Governing authority Section 766.9 Governing authority.— The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall (j) ensure the development and implementation of a patient complaint procedure to include: (1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received by the agency; (2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint; (i) explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and	H1014	**766.9(g) Governing Authority** During the last DOH survey in Port Jefferson, this issue came up and a letter was sent to DOH on 6/20/06 (Exhibit A) requesting removal of MSW from the license. The letter was not follow up when an amended license was not received. The VP of Patient Services spoke to Mikhail Pankov at DOH in NYC on April 9, 2010 and sent him a copy of our previous written request. He has assured us that he will forward this request to Albany for processing. As soon as the amended license is received, it will be posted in the Port Jefferson branch with the outdated license being returned to DOH. Compliance with what is stated on the agency license will be monitored during routine, internal biannual audits. Compliance is to be maintained at 100%. **Responsible individual – DCS and VP of Patient Services** **Completion Date – April 9, 2010** Attachment reviewed Accepted 4/30/10 SR	

PRINTED: 04/13/2010
FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0908D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSO	1010 ROUTE 112 PORT JEFFERSON STATI NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From page 8			

(ii) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed;

(3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal; and

(4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management.

This Regulation is not met as evidenced by:
Based on record review and staff interview, the Governing Authority (GA) failed to ensure that the agency develop a complete complaint procedure which includes the patient's right to an appeal process within thirty (30) days of receipt of the appeal. This was evident for the agency's Admission Packet.

Failure to develop a complete complaint procedure that includes the patient's right to an appeal places all patients at risk for not rights met.

The finding is:

The Patient Rights and Responsibilities provided to the patients in the agency's Admission Packet lacks documentation that the agency will notify the patients in writing of the patients' right to an appeals process which includes a review by a member of the agency's Governing Authority (GA) within thirty (30) days of receipt of the appeal.

The findings was reviewed with the agency's

H1020
766.9(j) Governing Authority
All Metro Health Care's Patient Bill of Rights (Exhibit B) was updated in 2008 to include accurate verbiage regarding the appeals process currently proscribed in the Patient's Bill of Rights.
All admission packets shall be reviewed to assure that the correct document is being used. Field Nurse Supervisors will be instructed to discard any forms that pre-date the current iteration, and all current patients will be sent a new Bill of Rights with a cover letter explaining their rights as outlined in item #23, with instruction to call the office if additional clarification is needed. Compliance will be monitored during routine internal audits conducted biannually.
Compliance is to be maintained at 90%.
Responsible individual – DCS and VP of Patient Services
Completion Date – May 31, 2010

Attachment reviewed
Accepted 4/30/10
SR

FORM APPROVED

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0908D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERSO	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From page 7 Director of Clinical Services (DCS) on 3/31/10 and was given an opportunity to provide an explanation. On 4/01/10, the DCS confirmed the survey findings and did not provide an explanation.	H1020		
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: ... (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided. The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of	H1036	**H1036** **766.9(l) Governing Authority** It is All Metro Health Care's policy that all Q.I. Meetings be attended by a consumer who is neither an owner nor employee of the Agency (Exhibit C). The branch lost their consumer and was having difficulty replacing that individual. They have now secured a new consumer, the DCS has been reoriented to the requirement for committee members to attend all meetings and that no more than one may be missed in any year by a given member. Compliance will be monitored during routine, internal biannual audits. Compliance is to be maintained at 100%. **Responsible Individual – DCS and VP of Patient Services** **Completion Date – April 26, 2010** Accepted 4/30/10 911 attachments reviewed SR	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0908D	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - PORT JEFFERS(	1010 ROUTE 112 PORT JEFFERSON STATI, NY 11776

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 8 review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the Governing Authority (GA) failed to ensure that Quality Improvement (QI) meetings are attended by the required members. This was evident in two (2) out of five (5) of the agency's QI meeting minutes for year 2009. Failure to ensure that the QI committee is attended by the required members places all patients at risk for poor quality care. The finding is: The QI committee meeting minutes dated 3/20/09 and 8/21/09 lack documentation of consumer attendance. On 3/31/10 at 2:30 PM, survey findings were discussed with the agency's Director of Clinical Services (DCS). The DCS stated that "we were having a problem with getting the Consumer to attend all the meetings, but we have secured a permanent Consumer now."	H1036	SL	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

April 12, 2010

Premier Home Health Care Services, Inc.
Attn: Donna Duggan, RN
Director of Clinical Services
80-02 Kew Gardens Road, Suite 600
Kew Gardens, NY 11415

Re: Response to Plan of Correction
License: 1086L006
Survey Date: 02/04/2010

Dear Ms. Duggan:

Please be advised that the Plan of Correction relating to the recent Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 427-4921.

Sincerely,

C. Phoenix-Tannis RN MSN P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

PREMIER
home health care services, inc.

March 26, 2010

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospices Services
Metropolitan Area Regional Office
90 Church Street
New York, New York 10007

RE: Premier Home Health Care Services, Inc. – Kew Gardens
License: 1086L006
Survey Date: February 4, 2010

Dear Ms. Phoenix-Tannis,

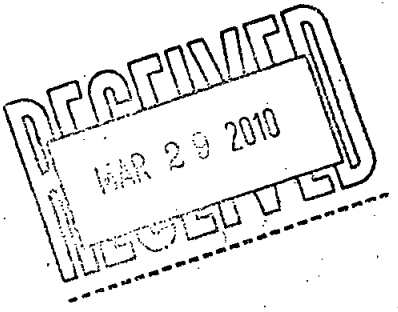
Attached, please find our plan of correction with the supporting documentation for the survey conducted on the above date.

The person responsible for overseeing the plan of correction will be Catherine Zhan, Regional Vice President.

If you have any questions, please feel free to contact me at 914 467-5567.

Sincerely,

Donna Duggan, RN
Director of Clinical Services



New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A re-licensure survey was conducted at Premier Home Health Care Services, Inc. (Kew Gardens) on February 4, 2010. Nine (9) personnel records were reviewed and are identified as Employee #1 to #9. Six (6) patient care records were reviewed and are identified as Patient #1 to #6. The Policy and Procedure Manual, Complaint Log and Quality Improvement meeting minutes were reviewed.	H 000		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency failed to maintain complete medical orders and to ensure medical orders are signed within 30 days by an authorized practitioner. This was evident for four (4) of six (6) patient care records reviewed (Patients #1, 2 3 and 4).	H 514		

Donna Duff, RN — Director of Clinical Services — 3/26/10

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 1 Failure to maintain complete medical orders and to ensure medical orders are signed within 30 days by an authorized practitioner places patients at risk for unsafe and unauthorized care. The findings are: 1) Patient #1 has diagnoses of: Multiple Sclerosis, Hypertension, History of Seizure Disorder, and Depression. The medical order initiated on "02/06/10 to 08/06/10" for Patient #1 documents a history of seizures. The medical order does not document seizure precautions. The medical order initiated on "02/06/10 to 08/06/10" includes an attached medication sheet. The attached medication sheet lacks documented evidence of physician signature and physician sign date. The medical order initiated on " 08/06/09 to 02/06/10 " lacks documented evidence of mental status. The medical order initiated on " 08/06/09 to 02/06/10 " lacks documented evidence of seizure precautions. The medical order initiated on " 02/06/09 to 08/06/09 " documents the physician sign date as " 05/26/09 ". The medical order initiated on " 02/06/09 to 08/06/09." for Patient #1 lacks a diagnosis of Multiple sclerosis. The medical order initiated on " 02/06/09 to 08/06/09 " includes an attached medication	H 514	**I. Corrective action for those patients found to be affected by the deficient practice:** **Patient #1** – FNS was re-educated on completion of POT including accurate diagnoses, medications to match diagnosis and safety precautions related to diagnosis. FNS was re-educated on POT requiring MD signature within 30 days and that both pages of POT need to be signed and dated by MD. • Medical order 2/6/10-8/6/10 has an attached medication sheet that does have the MD signature but the MD did not sign. • Medical order of 8/6/09- 2/6/10 does indicate mental status. • Medical order of 2/6/09-8/6/09 does indicate a diagnosis of Multiple Sclerosis. • Medical order of 2/6/09-8/6/09 does contain an MD signature, but the MD did not date the order. Addendum to POT sent to MD to correct this deficiency. **Patient #2** – FNS was re-educated on POT requiring MD signature within 30 days and that both pages of POT need to be signed and dated by MD including medication continuation sheet. • Medical order of 1/5/10-6/22/10 has an attached medication sheet that contains MD signature, but MD did not date. • Medical order of 7/5/09 – 1/5/10 includes an attached medication sheet that contains the MD signature, but MD did not date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 2 sheet. The attached medication sheet lacks documented evidence of physician signature and physician sign date. The medical order initiated " 08/06/08 to 02/06/09 " documents the physician sign date as " 09/16/08 ". The medical order initiated " 08/06/08 to 02/06/09 " lacks documented evidence of diagnoses for all medications. The medical order initiated " 02/06/08 to 08/06/08 " lacks documented evidence of physician signature and physician sign date. The medical order initiated " 02/06/08 to 08/06/08 " documents an addendum with a physician sign date of " 06/03/08 ". 2) Patient #2 has diagnoses of: Rheumatoid Arthritis and Chronic Obstructive Pulmonary Disease. The medical order initiated on " 01/05/10 to 06/2210 " includes an attached medication sheet. The attached medication sheet lacks documented evidence of physician signature and physician sign date. The medical order initiated " 07/05/09 to 01/05/10 " documents the physician sign date as " 08/12/09 ". The medical order initiated " 07/05/09 to 01/05/10 " includes an attached medication sheet. The attached medication sheet lacks documented evidence of physician signature and physician sign date.	H 514	**Patient #3** – FNS was re-educated on POT orders matching the HHA POC. HHA POC revised to accurately reflect the hours that the patient is receiving. **Patient #4** – Medical order of 1/4/10 – 7/4/10 documents renal diet and DC plan is checked off as **none at this time, long term care expected.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** 1. All case managed patients have the potential to be affected by this deficient practice. 2. The agency will perform 100% audit of the balance of the current population of case managed cases to assess for similar problems in this branch location. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. For the above project audit the Regional Director of Patient Services will be responsible for overseeing the audit process and then the Office Administrator moving forward. **2.** FNS's re-educated on completion of POT inclusive of diagnosis, medications, safety measures and obtaining MD signature within 30 days of order. 3. FNS's re-educated on accuracy of orders being reflected on HHA POC. **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** As is company practice, random quarterly chart audits will continue to ensure compliance with completion of plan of treatment and MD signature within 30 days.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 3 3) Patient #3 has diagnoses of: Hypertension, Glaucoma, and Hypothyroidism. The medical order initiated on " 06/01/09 to 12/01/09 " documents " 21 hours x 5 days for HHA/PCA " . The aide plan of care documents " 23 hours x 5 days " . 4) Patient #4 has diagnoses of: End Stage Renal Failure, Macular Degeneration, and Diabetes. The medical order initiated " 01/04/10 to 07/04/10 " fails to document patient ' s diet and discharge plans. On February 4, 2010 the Director of Patient Services was interviewed and did not provide an explanation.	H 514	1. The agency will perform 100% audit of the balance of the current population of case managed cases in this branch to ensure compliance. 2. Based on the structure established by the governing authority, audit results will continue to be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Regional DPS and Director of Clinical Services. Findings will be reviewed with the Office Administrator for resolution and reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The Regional DPS, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	5/31/10
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption;	H1036	**I. Corrective action for those patients found to be affected by the deficient practice:** There were no patients found to be affected by this regulation. Regional QI Committee does not require that a consumer be present, but rather Corporate QI require a consumer. The minutes reviewed by the surveyor after 2007 and cited for no consumer were as follows: • 11/4/08 – Regional QI • 12/3/08 – Corporate 2nd Q – consumer is identified as absent • 2/5/09 – Regional QI • 5/7/09 – Regional QI • 8/6/09 – Regional QI • 11/5/09 – Regional QI • 2009 – Corporate QI minutes for 1st, 2nd, 3rd, and 4th Quarters indentify consumer as Eileen Unrein. Consumer absent from 3rd Quarter.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 4 (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the Governing Authority failed to ensure the Quality Improvement (QI) Committee performs the required functions. This was evident for the agency Quality Improvement Committee meeting minutes. Failure to ensure the Quality Improvement Committee performs the required functions places patients at risk for receiving poor quality services, unsafe and inadequate care. The findings are: The QI meetings dated " 01/03/07 " , " 04/18/07 " , "05/17/07", " 09/20/07 " , " 12/20/07 " , " 11/04/08 " , " 12/03/08 " , " 02/05/09 " , " 05/07/09 " , " 08/06/09 " and " 11/05/09" lack documented evidence of consumer attendance. On February 4, 2010 the Director of Patient	H1036	**II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** 1. In the QI meeting minutes of 3/26/08, it was identified by the new VP of Clinical Services that a Consumer Representative was required. 2. A Consumer representative was appointed in 2008 and remains active on the committee. 3. VP of Clinical Services will continue to monitor consumer's attendance and participation on the committee. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. The QI Committee structure will continue to meet quarterly and minutes will reflect attendees. 2. The VP of Clinical Services will continue to monitor that all required attendees are active participants and in the event that committee members terminate membership, then alternates will be acquired. **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** Based on the structure established by the governing authority, the committee structure will remain in effect at the branch, regional, and corporate level with quarterly meetings.	5/31/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 5 Services was interviewed and did not provide an explanation.	H1036		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes	H1142		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 6 that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency did not maintain a complete and current Health Provider Network (HPN) Communications Directory. Failure to maintain a complete and current HPN Communications Directory places patients at risk for unsafe care during an emergent situation. The findings are: 1) The "Contact Information for Premier Home Health Care Services, Inc - Kew Gardens" lacks documentation of the names of the contact people for the following roles: 24 by 7 Facility Contact, Office of the Administrator, Criminal History Record Check Authorized Person (CHRC AP), Governing Body Chairman/President, Governing Body Member. On February 4, 2010 the Director of Patient Services was interviewed and did not provide an explanation.	H1142	**I. Corrective action for those patients found to be affected by the deficient practice:** There were no patients found to be affected by this regulation. **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** 1. The agency policy and procedure defines the necessary roles within the organization and the function of the HPN coordinator. 2. As is agency practice, the policies and procedures are reviewed annually. 3. Designated employees will be assigned to the role of: 7/24 Facility Contact, Office of the Administrator, Criminal History Record Check authorized person, Governing Body Chairman/President, Governing Body member. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. As is agency practice, the policies and procedures are reviewed annually. 2. An audit of the HPN system will be conducted to ensure current accurate information regarding role designation of employees and reviewed as an agenda item at the quarterly Corporate QI meeting. **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** This process will be monitored and overseen by the governing body and through the quarterly QI process.	5/31/10
H1338	766.11(g) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (g) that personnel records include verifications of employment history and qualifications for the	H1338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1338	Continued From page 7 duties assigned and, as appropriate, signed and dated applications for employment; records of professional licenses and registrations; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessment shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given patient medical records under section 766.6 of this Part. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not maintain complete personnel records for employees. This was evident for two (2) of nine (9) personnel records reviewed (Employees #5 and 6). Failure to maintain complete personnel records for employees places patients at risk for receiving poor quality of care from potentially unqualified personnel. The findings are: 1) Employee #5 is the Director of Patient Services hired by the agency on "12/01/07". The personnel record lacks documented evidence of: Orientation to agency policies and procedure/specific duties/emergency disaster plan upon hire; 2009 Annual Performance Evaluation; HIV Confidentiality and Universal Precautions training upon hire and 2008. 2) Employee #6 is a Registered Nurse hired by	H1338	**I. Corrective action for those patients found to be affected by the deficient practice:** There were no patients found to be affected by the deficient practice. **Employee #5** - 2009 Annual performance evaluation completed as indicated by cover page, but actual evaluation is missing. HIV confidentiality for 2007 was completed. HIV confidentiality and Standard Precautions was covered in an agency – wide RN orientation held 4/22/09. **Employee #6** HIV confidentiality and Standard Precautions was covered in an agency – wide RN orientation held 4/22/09. **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** All patients have the potential to be affected by this deficient practice.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1338	Continued From page 8 the agency on "11/03/08". The personnel record lacks documented evidence of HIV Confidentiality and Universal Precautions training upon hire. On February 4, 2010 the Director of Patient Services was interviewed and did not provide an explanation.	H1338	1. As is agency practice, quarterly audits will be done on 10% of employee records. 2. The audit process will be completed by the Compliance Coordinator and overseen by the Office Administrator. 3. Audit results will be reported at the Branch, Regional and Corporate QI Committee meetings. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. As is agency practice, quarterly audits will be done on 10% of employee records. 2. The audit process will be completed by the Compliance Coordinator and overseen by the Office Administrator. 3. Audit results will be reported at the Branch, Regional and Corporate QI Committee meetings. **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** 1. As is company practice, random monthly chart audits will continue to ensure compliance with this regulation. 2. Audits will be conducted by the compliance coordinator and overseen by the Office Administrator. 3. Based on the structure established by the governing authority, audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The Regional DPS, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	5/31/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 722	402.6(d) Criminal History Record Check Process Section 402.6 Criminal History Record Check Process. (d) A provider may temporarily approve a prospective employee while the results of the criminal history record check are pending. The provider shall implement the supervision requirements identified in section 402.4 of this Part, applicable to the provider, during the period of temporary employment. This Regulation is not met as evidenced by: Based on record reviews and staff interview, the agency did not document weekly supervision for all employees required to undergo a Criminal History Record Check (CHRC) until the results returned. This was evident for three (3) of six (6) Home Health Aide personnel records reviewed (Employees #1, 2 and 4). Failure to document weekly supervision while awaiting the results of the CHRC places patients at risk for receiving unsafe care. The findings are: 1) Employee #1 is a Home Health Aide hired by the agency on "10/28/08". 2) Employee #2 is a Home Health Aide hired by the agency on "11/17/08". 3) Employee #4 is a Home Health Aide hired by the agency on "04/20/07". There is no documented evidence of weekly supervision of Employees #1, 2 and 4 while awaiting the results of the criminal history record check until the CHRC results returned. On February 4, 2010 the Director of Patient	R 722	**I. Corrective action for those patients found to be affected by the deficient practice:** **Employee #1** – The employee's date of hire was 10/28/08. The employee was supervised 11/08/08 and the CHRC returned 11/9/08. No other provisional's required. **Employee #2** – The employee's date of hire was 11/17/08. Provisional's were completed 12/11/08 and 12/24/08. CHRC was returned 1/7/09. No other provisional's required. **Employee #4** – The employee's date of hire was 4/20/07. The reason that there are not documented weekly supervision's is because the employee did not work consistently. **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** 1. As is agency practice, quarterly audits will be done on 10% of employee records. 2. The audit process will be completed by the Compliance Coordinator and overseen by the Office Administrator. 3. Audit results will be reported at the Branch, Regional and Corporate QI Committee meetings. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. As is agency practice, quarterly audits will be done on 10% of employee records. 2. The audit process will be completed by the Compliance Coordinator and overseen by the Office Administrator. 3. Audit results will be reported at the Branch, Regional and Corporate QI Committee meetings.	5/31/10

Sandra Sell, RN — Director of Clinical Services — 3/26/10

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 722	Continued From page 1 Services was interviewed and did not provide an explanation.	R 722	**IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** 1. As is company practice, random monthly chart audits will continue to ensure compliance with this regulation. 2. Audits will be conducted by the compliance coordinator and overseen by the Office Administrator. 3. Based on the structure established by the governing authority. audit results will be documented on the Branch, Regional and Corporate QI Summary Forms. Results will be reviewed by the Office Administrator and Director of Clinical Services. Findings will be reported at the Branch, Regional and governing authority Corporate QI Committee meetings and reflected in the minutes. The VP of Operations, Office Administrator and Director of Clinical Services, based on the findings will determine if the system is effective and make any revisions as necessary.	
R 808	402.7(a)(2)(i) Department Criminal History Review Section 402.7 Department Criminal History Review. (a) After reviewing a criminal history record of an individual who is subject to a criminal history record check pursuant to this Part, the Department and the provider shall take the following actions: (2) Where the criminal history information of a prospective employee reveals a felony conviction at any time for a sex offense, a felony conviction within the past ten years involving violence, or a conviction for endangering the welfare of an incompetent or physically disabled person pursuant to section 260.25 of the Penal Law, or where the criminal history information concerning such prospective employee reveals a conviction at anytime of any class A felony, a conviction within the past ten years of any class B or C felony, any class D or E felony defined in articles 120, 130, 155, 160, 178 or 220 of the Penal Law or any crime defined in sections 260.32 or 260.34 of the Penal Law or any comparable offense in any other jurisdiction, the Department shall propose disapproval of such person ' s eligibility for employment unless the Department determines, in its discretion, that the prospective employee ' s employment will not in any way jeopardize the health, safety or welfare of patients, residents or clients of the provider. (i) The Department shall provide to the provider and the prospective employee, in writing, a summary of the criminal history information along with the notification identified in this paragraph.	R 808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 808	Continued From page 2 Upon the provider ' s receipt from the Department of a notification of proposed disapproval of eligibility for employment, the provider shall not allow the prospective employee to provide direct care or supervision to patients, residents, or clients of such provider until receipt of a final determination of eligibility for employment from the Department. This Regulation is not met as evidenced by: Based on record reviews and staff interview the agency did not document the immediate removal of employees with negative Criminal History Record Check (CHRC) determination letters from direct care or supervision to patients, residents, or clients. This was evident for one (1) of nine (9) personnel records reviewed (Employee # 8). Failure to document the termination dates for employees with negative CHRC determination letters places patients at risk for receiving unsafe care from employees with a criminal history. The finding is: 1) Employee #8 ' s personnel record documents a negative determination letter dated "10/01/09". The employee record lacks documentation of immediate removal from direct care of patients upon agency receipt of the negative determination letter. On February 4, 2010 the Director of Patient Services was interviewed and did not provide an explanation.	R 808	There was no deficient practice by the agency. **Employee #8** – Although a negative determination letter was received, the individual was never hired because she did not complete the training class (specifically, her SPT's were not completed). She was not placed on any cases, since she was never hired or an employee.	3/4/10
R1022	402.9(b)(2) Responsibilities of Providers; Required Notif	R1022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R1022	Continued From page 3 Section 402.9 Responsibilities of Providers; Required Notifications. (b) Notifications. A provider must immediately, but within no later than 30 calendar days after the event, notify the Department, and document such notification occurred, when: (2) any employee who was subject to, and underwent, a criminal history record check in accordance with this Part is no longer employed by the provider. This Regulation is not met as evidenced by: Based on staff interview, the agency did not have documentation the New York State Department of Health is notified within 30 calendar days of when an employee who underwent a Criminal History Record Check (CHRC) is no longer employed. This was evident for two (2) of nine (9) Home Health Aide personnel records reviewed (Employees #8 and 9). Failure to notify the Department of Health within 30 calendar days of when an employee who underwent a CHRC is no longer employed places patients at risk for receiving unsafe care. The findings are: Employees # 8 and 9 underwent a CHRC and are no longer employees of the agency. There is no documented evidence of when the agency submitted the CHRC termination form 105 through the Health Provider Network (HPN). On February 4, 2010 the Director of Patient Services was interviewed and did not provide an explanation.	R1022	There was no deficient practice by the agency. **Employees #8 and #9** – these two individuals were never hired and therefore were not employees of the agency. **I. Corrective action for those patients found to be affected by the deficient practice:** There were no patients affected by this deficient practice. **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** The agency policy and procedure has been updated to reflect compliance with this regulation.	3/14/10 2/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0584C	A. BUILDING _____ B. WING _____	02/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	80-02 KEW GARDENS ROAD, SUITE 600 KEW GARDENS, NY 11415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R1034	402.9(d) Responsibilities of Providers; Required Notif Section 402.9 Responsibilities of Providers; Required Notifications. (d) Policies and procedures. Each provider subject to the provisions of this Part shall have policies and procedures designed to implement the provisions of this Part. Amendment of existing personnel policies and procedures to reflect these new requirements is sufficient compliance with this subdivision. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to revise Criminal History Record Check (CHRC) policies and procedures. Failure to revise Criminal History Record Check policies and procedures fails to ensure agency employees are implementing the CHRC according to regulations. The findings are: The agency Criminal History Record Check policy and procedure did not contain documented evidence of the following: timeliness and prohibiting the charging of employees for the CHRC. On February 4, 2010 the Director of Patient Services was interviewed and did not provide an explanation.	R1034	**III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** As is company practice, all policies and procedures will be reviewed annually to maintain compliance with regulatory standards. **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** As is company practice, the process of reviewing and updating agency policy annually will be overseen by the governing authority.	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

April 15, 2010

All Metro Health Care – New York
Attn: Cathy Kelly, RN
Senior VP of Patient Services
80 Broad Street, 14th Floor
New York, NY 10004

Re: Response to Plan of Correction
License: 1394L006
Survey Date: 8/4/2009

Dear Ms. Kelly:

Please be advised that the Plan of Correction relating to the recent State Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 427-4921.

Sincerely,

C. Phoenix-Tannis, M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt
cc: Susan Olivet-Conde, Branch Manager
Dave Middleton, President/COO

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A re-licensure survey was conducted at All Metro Health Care Inc. on August 3, 2009 and August 4, 2009. Six (6) Patient Care Records were reviewed including two (2) discharged patient care records and are identified as Patients #1 to #6. Six (6) Personnel Records were reviewed and are identified as Employees #1 to #6. The Quality Improvement Committee Meeting Minutes dated from August 2007- present, Complaint Log, Admission Packet with brochure and the Policy and Procedure Manuals were reviewed. The Health Provider Network (HPN) log-on process by the Director of Clinical Services (DCS) was observed.	H 000		
H 224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the	H 224		

ew York State Department of Health

TEMENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 1 provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management. This Regulation is not met as evidenced by: Based on records review and interview, the agency failed to inform patients of the complete procedure for the agency ' s response to complaints. This was evident for the agency " Patient Rights and Responsibilities " observed in the Admission Packet and for six (6) out of six (6) patient care records (Patients #1, #2, #3, #4, #5, #6). Failure to provide patients with the correct complaint information places patients at risk for not being able to fully exercise their rights when filing a complaint. The findings are: The agency " Patient Rights and Responsibilities " observed in the Admission Packet documents: " Be informed of the procedure of submitting a written complaint/grievance to All Metro Health Care. You shall receive a prompt and reasonable response regarding the complaint/ grievance within 15 days. " The agency: " ... Patient Admission Policy Acknowledgement " documents that Patients #1 through #6 received the agency " Patient Rights and Responsibilities. " There is no documented evidence of informing patients of the right to appeal the outcome of the agency ' s investigation and the appeals procedure to be followed by the agency.	H 224	**H224 – 766.1(a)(9) Patient Rights** The Bill of Rights was updated during the survey with the amendments being acceptable to the surveyors (Exhibit 1). The amended document is currently in use and will be distributed and explained to all existing patients during the next supervisory visit or by mail. Verification of the implementation of the updated document will be monitored during biannual internal audits by the Department of Patient Services **Responsible individual** – Director of Clinical Services and VP of Patient Services **Completion date – 12/1/09**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 2 On August 4, 2009 at 11:30am the Director of Clinical Services (DCS) was interviewed and stated: " If the patient complains, then we tell them the procedure " and did not provide further explanation.	H 224		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on records review and interview, the agency failed to ensure that medical orders are authenticated by an authorized practitioner and reference health care needs. This was evident for four (4) of six (6) patient care records reviewed (Patients #1, #2, #3, #6). Failure of the agency to obtain medical orders for all health care needs places patients at risk for not having all of their needs met. The findings are: 1. Patient # 1 - admitted to the agency on " 7/30/08 " with diagnoses which include Brain	H 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILOING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 3 Tumor, Seizure Disorder, Left Hemiparalysis, and Left Visual Field Deficit. The agency " Medical Request for Home Care Form M-11Q " dated " 6/6/07 " "12/17/08 " documents: " Date of next examination: pending. " There is no documented evidence of medical orders between the dates " 6/6/08 to 12/17/08. " The medical order dated " 12/17/08 " does not document medications. The agency " Nurse ' s Assessment Visit Report " dated " 7/18/09 " documents the following medications: " Protonix 40mg Daily oral, Baclofen 10mg Daily Oral, Carbamezepine 200mg Daily Oral, Vitamin D 50,000mg Daily Oral, Prochlorperazine 10mg Q8hrs as needed oral, Diphenhydramine 25 mg Q8hrs as needed oral, Butalbuterol/APA/CR 325 -40 mg Q6prn, Tylenol #3 oral Q6 hrs as needed, Zolpidex 10mg oral at bedtime, Calcium Carb/ Vit. D 60/125mg 2x a day, Actonel 35mg daily, Docusate 200mg oral 3x a day, Senna one tab, Calcium D-500mg daily. " There is no documented evidence that the medical orders were reviewed and subsequently revised to reflect the changes in the patient ' s medication regimen based on these additional medications. On August 4, 2009 at 2:14pm, the Director of Clinical Services (DCS) stated: " They only get an M11Q once a year, the nurse goes out if there ' s a change " and did not provide further explanation. 2. Patient #2 - admitted to the agency on " 1/2/06 " has diagnoses which include Dementia,	H 514		

New York State Department of Health

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 4 Hyperlipidemia, Diabetes NIDDM Type 2, Hypertension. The agency " Home Health Certification and Plan of Care " dated " 7/1/2007 to 12/31/2007 " documents the following medications: " Pepcid AC 20mg daily po, Omeprazole 20mg daily po. " The agency " Home Health Certification and Plan of Care " dated " 12/31/2007 to 7/1/2008 " " 7/1/2008 to 12/31/2008 " " 12/31/2008 to 7/2/2009 " documents the following medications: " Pepcid AC 20mg daily po. " There is no documented evidence of a diagnosis corresponding with the medications Pepcid and Omeprazole. On August 4, 2009 at 2:05pm the Director of Clinical Services (DCS) was interviewed and did not provide an explanation. 3. Patient #3 - admitted to the agency on " 11/18/08 " has diagnoses which include Back Contusion, Knee Replacement Right or Left. " The agency " Home Health Certification and Plan of Care " dated " 11/18/2008 to 5/21/2009 " documents the following medications: " Zoloft 50mg daily po, Prilosec 20mg daily po, Amiloride 1 tab PRN po- for edema. " The agency " Home Health Certification and Plan of Care " dated " 5/21/2009 to 11/20/2009 " documents the following medications: " Zoloft 50mg daily po, Prilosec 20mg daily po, Moduretic 1 tab daily po. " The agency " Medication Profile " that is not dated documents " DX: Fx Rt Knee, Bursitis Rt	H 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 5 Hip, Spinal Stenosis, Congestive Heart Failure (CHF), Depression. " There is no documented evidence of a diagnosis corresponding with the medications Prilosec. There is no documented evidence of the dosage for the medications Amiloride, Moduretic on the agency " Home Health Certification and Plan of Care " dated " 11/18/2008 to 5/21/2009 " and " 5/21/2009 to 11/20/2009. " On August 4, 2009 at 2:05pm the DCS and Administrator were interviewed and did not provide an explanation. 4. Patient #6 - admitted to the agency on " 12/31/2007 " has diagnoses which include Parkinson ' s Disease, ORIF, Urinary Tract Infection (UTI), Prostatic Hypertrophy. The agency " Home Health Certification and Plan of Care " dated " 12/31/2007 to 6/30/2008 " and " 6/30/2008 to 12/30/2008 " documents the following " Surgical Procedure- ORIF. " There is no documented evidence on the medical order to identify the patient ' s physical site for this procedure. The agency " Physician ' s Telephone Orders " dated " 3/31/08 " documents: "... Received verbal order to assist with range of motion (ROM) as assigned. " There is no documented evidence that the medical orders indicate the type of ROM ordered. On August 4, 2009 at 2:45pm the DCS and Administrator were interviewed and did not provide an explanation.	H 514	**H514 – 766.4(d) – Medical Orders** 1.Pt. #1 is an HRA patient, and per the contract (Exhibit 2 and 2A) Medical Orders are the responsibility of the Case Manager, HRA. The orders for HRA clients are the M11Q, which is obtained by HRA from the patient's medical provider and forwarded to All Metro. The Nursing Supervisory Report was forwarded to HRA after the visit for HRA's review and any necessary amendments by HRA to the M11Q, as the DCS discussed with the surveyors. 2 & 3. Regarding the three private patients (2, 3 &6): All nurses have all been reoriented by the DCS to our policy requiring them to date each individual medication, not just the first in the list. Additionally, beginning 11/08, we implemented a new Medication Profile that includes the dx. associated with each med (Exhibit 3). All patient files have the current Medication Profile in place. Each med. appearing on the Med Profile corresponds with a med. that the MD has validated on the POC. Many of our patients take meds. for prophylaxis rather than an active dx. for which they are receiving paraprofessional care. Files will continue to be reviewed for congruence between POC's and Med Profiles during routine internal audits done by the Department of Patient Services. Med Profiles are also reviewed for completeness by both the DCS upon submission, and during routine internal audits. All active, case managed cases will be reviewed for these items by 10/15/09. 4. Patient 6 has been discharged. Moving forward, the DCS will f/u with any incomplete information regarding surgical site and assure that it appears on the POC. Additionally, ROM will be specified as "active/passive" on the POC and all other documents, including the Aide Care Plan. Only HHA's may perform active ROM with a written exercise plan to guide them. Files will continue to be reviewed for proper documentation during routine internal audits done by the Department of Patient Services. **Responsible individual** – Director of Clinical Services and VP of Patient Services **Completion date – 10/15/09**	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 6	H1036		
H1036	766.9(l) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (l) appoint a quality improvement committee to establish and oversee standards of care. The quality improvement committee shall consist of a consumer and appropriate health professional persons including a physician if professional health care services are provided.The committee shall meet at least four times a year to: (1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption; (2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes: (i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and (ii) all cases with identified patient complaints as specified in subdivision (j) of this section; (3) prepare and submit a written summary of review findings to the governing authority for necessary action; and (4) assist the agency in maintaining liaison with other health care providers in the community. This Regulation is not met as evidenced by:	H1036		

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 7 Based on records review and interview, the agency failed to ensure that the Quality Improvement (QI) Committee performed all the required functions. This was evident for the agency Quality Improvement Committee Meeting Minutes. Failure to ensure that the agency QI Committee performs all the required duties has the potential for lack of oversight to the quality of services provided to agency patients. The findings are: 1. The QI Committee Meeting Minutes dated " September 26, 2007 " documents " There were no complaints logged for 2nd Quarter. Discussion ensued on the accuracy of this. " The agency " Patient Grievance/Complaint Log " documents that a complaint was made " 5/29/07. " There is no documented evidence that the complaint generated during the second quarter of 2007 was discussed during this meeting. The QI Committee Meeting Minutes dated " March 25, 2008 " documents: " Complaints: None recorded in 4th Quarter. " The agency " Patient Grievance/Complaint Log " documents four (4) complaints were made on the following dates: " 10/8/07, 11/19/07, 11/23/07, and 12/10/07. " There is no documented evidence that these complaints generated during the fourth quarter of 2007 were discussed during this meeting. 2. There is no documented evidence of the	H1036	**H1036 – 766.9 Governing Authority** 1. Grievance/Complaint of 5/29/07 that was not reported to the committee will be presented at the meeting of 9/25/09, as well as the unreported complaints of 10/8/07, 11/19/07, 11/23/07 and 12/7/07. Moving forward, the DCS will check the log for Complaints before each Q.I. Meeting to assure that all complaints are reported, and the minutes will reflect this review. Compliance will be monitored during semi-annual internal audits by the Department of Patient Services. 2. It is All Metro's policy that a random sample of active and discharged clients be reviewed during each Q.I. Meeting for safety, adequacy and type and quality of service. The minutes of 3/25/08 (Exhibit 4) indicate the results of a U/R for 4th quarter 07, attached (Exhibit 5A & B) which includes 2 discharged records - moving forward, these U/R's will be attached to the minutes for reference. Also included is the U/R for the Q.I. Meeting of Dec. 19, 2007, although we could not locate the D/C record review. This requirement has been reinforced with the staff and will be reviewed during semi-annual internal quality audits performed by the Department of Patient Services. 3. We have dealt with this issue in the past and were informed by DOH that the standard allowed that a member may miss no more than one (1) meeting a year before a citation results. We have updated our Q.I. Committee policy (Exhibit 6) to incorporate this standard. Additionally, Dr. Drescher was sent the minutes which he read and signed (Exhibit 7) Page one of the minutes for 2008 indicating the attendees (Exhibit 8) are attached confirming that our consumer was present at three of four meetings, which complies with the standard as we understand it. **Responsible Individual** – Director of Clinical Services, VP of Patient Services **Completion date – 12/1/09**	

New York State Department of Health

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0412D	A. BUILDING _____ B. WING _____	08/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL METRO HEALTH CARE - NEW YORK	80 BROAD STREET, 14TH FLOOR NEW YORK, NY 10004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1036	Continued From page 8 discussion of a random selection of clinical records review for patients receiving services and patients that have been discharged for the meetings dated " December 19, 2007. " 3. There is no documented evidence of the attendance of a consumer for the QI Committee meeting dated " March 25, 2008. " There is no documented evidence of the attendance of a physician for the meeting dated " March 13, 2009. " On August 4, 2009 at 2:05pm, the Director of Clinical Services (DCS) and Administrator were interviewed and did not provide an explanation.	H1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
J1456	763.13(k) Personnel 763.13 Personnel (k) that an annual assessment of the performance and effectiveness of each person is conducted and documented in writing, including at least one home visit to observe performance if the person provides services in the home; and This Regulation is not met as evidenced by: Based on personnel record reviews and staff interview, the agency failed to complete annual assessments of the performance and effectiveness for employees which includes at least on in-home observation. This was evident for three (3) of eight (8) employees requiring annual performance evaluations (Employees #1, #3, and #7). Failure to perform an annual performance assessment of staff which includes at least one in-home observation places all patients at risk for poor quality care. The findings are: 1)Employee #1 is a Registered Nurse (RN) with a hire date of 6/02/08. The personnel record documents an annual performance assessment dated 9/28/09. The performance assessment lacks documentation that an in-home visit was conducted. 2) Employee #3 is a RN with a hire date of 4/03/06. The personnel record documents an annual performance assessment was dated	J1456	It is Americare CSS policy that all employees receive a Performance Evaluation on their anniversary date. All nurses performing patient visits in addition receive a field assessment in addition to their annual performance evaluation. Up until the time of survey the field visits were not considered a part of the Human Resource file. They were kept in the Suffern Office by the dedicated Supervisor. The Supervisors visit the adult homes on at least bi-weekly basis. So any nursing employee can be the subject of an unscheduled supervisory visit at any time. Since the survey of 05/10/10 all annual assessments, evaluations and unsatisfactory supervisory visits will be forwarded to Human Resources to be incorporated in the employee's files along with a Performance Plan and/or Disciplinary action. Upon DOH exit interview the Human Resource Department was contacted for a list of employee performance and evaluation due dates. A meeting was conducted with each Supervisor to impress upon them the urgency of timely completion. <u>All outstanding Performance evaluations will be completed by 06/30/10.</u> Effective June 14, 2010 a Clerk was hired to track performance evaluations and forward them to Human Resources for incorporation into the employees file. TN	05/20/10 06/14/10 & On-going

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Associate Administrator — (X6) DATE

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
J1456	Continued From page 1 3/31/09. The performance assessment lacks documentation that an in-home visit was conducted. 3) Employee #7 is a Home Health Aide (hha) with a hire date of 12/07/01. The last documented annual performance assessment is dated 8/07/08. The personnel record lacks an annual performance assessment for year 2009. Interview with the Nursing Supervisor on 5/12/10, the Nursing Supervisor stated that she could not find the missing documents.	J1456	The clerk will review the list monthly & alert the Supervisor and Associate Administrator of pending & over due performance evaluations. In addition, the Human Resource department in Brooklyn will conduct random employee chart audits on a monthly basis. T/C 6/7/10 10:30 AM Target goal 100% if not met + re-inservice of resp. staff & discipline as necessary Accepted 6/7/10 TR	

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS A Re-certification survey was conducted at the agency's branch office located at 900 Merchants Concourse Westbury, NY on May 10 – 12, 2010. Fifteen (15) clinical records were reviewed and identified as Patients #1-# 15. Home visits were made to Patients #2, #4, #6; #7 and # 8. Nine (9) personnel records were reviewed and identified as Employees #1-#9. The Agency Emergency preparedness Plan policy and procedure, Health Provider Network policy and procedure and account, and Criminal History Record Check policy and procedure were reviewed.	G 000		
G145	484.14(g) COORDINATION OF PATIENT SERVICES A written Summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on Clinical record reviews and staff interview, the agency failed to ensure that the documentation of patient's weights on the written 60 day summary is accurate. This was evident in four (4) of thirteen (13) clinical records. Requiring a written 60 day summary. (Patients #2, #3, #6 and #7) Failure to provide accurate information on the written 60 day summary to the physician places all patients at risk for poor coordination of care.	G145	To ensure that all personnel provide a written summary report for each patient is sent to the attending physician at least every 60 days with a comprehensive review of the patient's total progress the following will take place: 1. A Nursing in-service was conducted within Suffern and Westbury office locations to review the DOH Plan of Correction and to review Americare CSS policy and procedures to ensure that 60 day summaries meet the regulatory requirements of §482.2.	05/19/10 Suffern & 5/20/10 in Westbury TW

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Associate Administrator | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation .

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	**ADDENDUM TO PAGE 1**	G 145	2. Patient's # 2, 6, 7 & 9 (75%) of the identified patients) were serviced by the same nurse all within the same location (Sachem Adult Home). The nurse was counseled and in-serviced on the policy and procedure for writing comprehensive 60-day summaries and documenting accurate patient information including but not limited to vital signs and accurate weights. In addition the nurse for patient #3 was also counseled regarding comprehensive documentation.	05/20/10
			3. In all of the above patient's the MD was contacted for clarification of weight orders and interim orders were sent for MD signature.	05/31/10
			4. The Adult Home Supervisor and/or the QI Manager will do a 100% audit of Westbury charts every 60 days and a <u>100% audit of 60 day summaries in Suffern for the next quarter then 10% random audit ongoing</u>. The results of these audits will be discussed with the nurses on an individual basis, discussed monthly at the Nursing Staff meeting, reported to the QI Management meeting and to the Associate Administrator and Administrator in the weekly Agency Tracking & Trending Report and to the Chief Operating Officer/VP and to the Professional Advisory Board on a quarterly basis.	09/01/10 & on-going <u>Audit to be completed by 09/01/10</u> 09/01/10 & on-going
			5. The Associate Administrator is ultimately responsible to ensure the Plan of Correction is carried out.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Associate Administrator — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE CERTIFIED SPECIAL SERVICES	100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued From page 1 The findings are: 1) Patient #9 has an admission date of 11/10/09 With diagnoses of Hypertension, Paranoid Schizophrenia and Chronic Airway Obstruction. The Plan of Care (POC) dated 3/10/10-5/08/10 Document order for the Skilled Nurse (SN to "weigh patient monthly, report to MD (physician) 10lbs (pound) weight gain or loss in one month". The nursing visit notes dated 3/16/10 – 5/4/10 Lack documentation of the patient's monthly weight. The "Monthly Weights"log revised "3/06" which is Maintained in the Adult Care Facility (ACF) in Which the patient resides documents the patient's Monthly weights as 154 lbs in March, 155 lbs in April and 155 lbs in May 2010. The agency "Recert/60 days Summary" dated 5/04/10 documents the patients weight as "160 lbs-165lbs. The SN failed to document the patient's accurate weight and failed to notify the attending physician of the patients actual weight. 2) Patient #2 has an admission date of 7/18/06 with a diagnosis of Schizophrenia. The POC dated 2/27/10-4/27/10 and 4/28/10 – 6/26/10 document orders for the SN to "weigh patient monthly, report to MD 10 lbs weight gain or loss in one month". The "Monthly Weights" log documents the patient's weight as "145 lbs" on 3/01/10 and 160 lbs on 4/01/10 and 5/03/10.	G 145	6. Results of the QI audits will be discussed with the nurses directly, a performance improvement plan will be developed and if there is no improvement the nurse will be subject to disciplinary action, continued non-compliance will result in suspension and/or termination. 7. The 100% 60 day audit will be completed on 09/01/10. If nurses are found to be deficient after 09/01/10 they will be subject to further disciplinary action. Accepted 6/7/10 TW	

Amended X1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued From page 2 The agency "Recert/60 Days Summary" dated 4/26/10 documents the patient's weight as "150 – 155" lbs. The SN failed to provide documentation of the accurate range of the patient's weights to the physician. 3) Patient #3 has an admission date of 3/9/10 with a diagnosis of Schizophrenia. The POC dated 3/9/10-5/7/10 documents an order for the SN to "weigh patient monthly, report to MD 10 lbs weight gain or loss in one month". The "Monthly Weights" log documents the patient's weight as "240 lbs on 3/2/10 and "230 lbs on 4/01/10 and 5/03/10. The agency's "Recert/60 Days Summary" dated 5/4/10 documents the patient's weight as "200 – 225" lbs. The SN failed to provide documentation of the accurate range of the patient's weights to the physician. 4) Patient #6 has an admission date of 12/14/09 with a diagnoses including Diabetes Mellitus, Schizophrenia, and Hypertension. The POC dated 3/8/10 – 5/8/10 documents an order for the SN to "weigh patient monthly, report to MD 10lbs weight gain or loss in one month". The "Monthly Weights" log documents the patient's weight as "201" lbs on 2/03/10, "190" lbs on 3/02/10, and "200" lbs on 4/01/10. The agency "Recert/60 Day Summary" dated 3/08/10 documents the patient's weights as "180" lbs and "Recert/60 Day Summary" dated 5/04/10 documents the patient's weigh as "160 – 180"lbs.	G 145		TN

Amended X1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued from page 3 The SN failed to provide documentation of the Accurate range of the patient's weights to the Physician for 2 Recert/60 Day Summaries. Interview with the Nursing Supervisor on 5/12/10, The Nursing Supervisor stated that she spoke to The SN and the SN stated that "she had not reviewed the monthly weight log while writing Recert/60 Day Summaries".	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, Osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, home visit (HV), And staff interview, the agency staff failed to Monitor patients' weight and provide wound Assessments/wound care as directed in the Plan Of Care (POC). This was evident in nine (9) of fifteen (15) clinical records reviewed. (Patients #1, #2 HV #3, #5, #6 HV, #7 HV, #10, #13 and #14). Findings to provide care as directed in the POC places all patients at risk for not having their care Needs met. The findings are: 1) Patient #13 has an admission date of 3/25/10 with a diagnosis of Disruption of Wound The POC dated 3/25/10-5/23/10 document orders for the Skilled Nurse (SN) to perform	G 158	As per §484.18 Acceptance of Patients, POC and Medical Supervision all medical orders for specific ranges are carried out per MD order and the physician is alerted timely of changes in the patient's condition. 1. An in-service was conducted in each branch location to reinforce the above standard. (See attached in-service minutes and attendance sign-in sheet). 2. A memo was sent out to all active nurses outlining the policy and procedure regarding Acceptance of Patients, POC and Medical Supervision. (See attached memo). 3. The MD was contacted for clarification of ranges and to obtain new orders regarding notification of changes in patient's condition on the following patient's # 1, #2, #3,#5,#6,#7, #10,#13, and #14.	05/19/10 Suffern & 05/20/10 in Westbury 05/24/10 05/31/10

Amended XI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 4 wound assessment and wound care. The nursing visit notes dated 3/29/10-4/09/10 lack documentation that the nurse notified the physician of the patient's purulent wound drainage. The Start of Care Assessment dated 3/27/10, the nurse documents that the patient has one (1) wound measuring "6- cm (centimeters) X 27 cm length". On 3/29/10, the nurse documents: "purulent large drainage present to surgical wound. Gastrostomy tube intact, peri wound red (+) purulent drainage. Continues on ABT (antibiotic therapy). Pt. (patient) to go to hospital for temperature of 101F or greater". On 3/30/10, the nurse documents "purulent drainage, non ordorous. Continues on antibiotics. Follow up appointment 4/02/10". On 3/31/10, the nurse documents "drainage from surgical opening purulent". On 4/01/10, the nurse documents "drainage from abd. (abdominal) wound remains purulent, amount is now moderate. Gastrostomy tube site is redden/periwound from perulent drainage. The nursing visit notes lack documentation that The physician was notified of the patient's purulent Wound drainage from 3/29-4/01/10. On 4/02/10, the nurse documents: "seen by DR (doctor), staples removed, small amount of Yellow drainage to surgical wound, non ordorous ABT have been d/c'ed (discontinued)".	G 158	4. The Adult Home Supervisor and/or the QI Manager will do a 100% review audit of Westbury clinical records every 60 days and a 100% audit of 60 day summaries in Suffern for the next quarter then 10% random audit ongoing. The results of these audits will be discussed with the nurses on an individual basis, discussed monthly at the Nursing Staff meeting, reported to the QI Management meeting and to the Associate Administrator and Administrator in the weekly Agency Tracking & Trending Report and to the Chief Operating Officer /VP and to the Professional Advisory Board on a quarterly basis. 5. The Supervisors/QI Manager and/or designee will complete Mock Surveys on a quarterly basis. The results will be given to the Associate Administrator who will present the findings to the Administrator, Chief Operating Officer/VP and to the Professional Advisory Committee on a quarterly basis. 6. The Associate Administrator is ultimately responsible to ensure the Plan of Correction is carried out. 7. Patient # 13, the nurse was counseled regarding comprehensive documentation of patient clinical status. Unfortunately, her documentation did not reflect her actions. Upon questioning her and the MD it was apparent that multiple discussions occurred regarding the patient status. The MD was aware of the purulent drainage, size of wound, dehiscence and temperature of 101.1 degrees. The nurse failed to	09/01/10 & on-going Audits to be completed by 09/01/10 09/23/10 & on-going 09/01/10 & on-going

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 5 On 4/03/10, the nurse documents: "noted periwound opening about 3 cm (centimeters) above surgical opening, site approximately 1-2 cm oozing small amount of drainage when wound irrigated". "sm (small) amount of beige secretions to abd wound non odorous, temp fluctuate 99-100, next MD (physician) appointment 4/08/10". On 4/04/10, the nurse documents: "1/2 cm wound dehiscience above abd wound, approx 3-4 cm above abd wound". The nurse documents the patient has a temperature of 100.3F. On 4/05/10, the nurse documents: "small area above surgical wound approx 3cm above site dehisced area approx ½ cm". There is no documentations that the nurse notified the physician of the patients purulent wound drainage and that the wound dehisced 4/03 – 4/05/10. On 4/06/10, the nurse documents: "drainage moderate, beige non – odorous, periwound around ostomy less redness". The nurse documents: "next MD visit 4/07/10 – Oncologist and 4/08/10 Surgeon". The record contains a "Missed Visit Report" dated 4/07/10 due to physician appointment. On 4/08/10, the nurse documents patient "now has 3 (three) abd (abdominal) wounds". There is no documentation that the nurse communicated with the physician about the status of the wounds and that the POC is reviewed. On 4/09/10, the nurse documents: "sm (small)	G 158	document the discussions within her clinical notes. Pictures of the wound were taken and sent to the MD. The patient was also being seen at the wound clinic on a weekly basis. The nurse seeing the patient is a Certified Wound Specialist. The MD was impressed by her knowledge and skills in treating the patient. 8. The nurse servicing patient # 10 was counseled on 05/19/10 regarding proper wound care and documentation. 9. The Suffern office will be reviewing 100% of all wound care patient's to assure clinical documentation is comprehensive and that changes in the patient status are reported and documented timely. 10. Failure to document comprehensively will result in further disciplinary actions leading up to suspension and termination. T/C 6/7/10 10:30 Ass Admx 100% target goal & if not met re-inservice + discipline staff as needed Accepted 6/7/10 TD	12/31/10

Amended 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 6 abscess to R (right) side of abdomen with sm (small) amount of purulent drainages site approximately 1cm circular". The nurse further document increase "visit frequency to 2X per day V.O. (verbal order)". There is no documentation that the nurse communicated to the physician the status of the patient's purulent wound drainage from 3/29/10 through 4/8/10. The record lacks documentation that the nurse communicated to the physician that the wound dehisced. On 5/11/10, survey findings were discussed with the agency's Clinical Manager and Administrator. On 5/21/10, the Clinical Manager provided an "Exception Log" dated 4/06/10 documenting "MD attempted unavailable, MD appointment set 4/07/10". 2) Patient #10 has an admission date of 4/12/10 with the diagnoses of Surgical Aftercare, Dementia and Alzheimer's Disease. The POC dated 4/21/10 – 6/10/10 documents orders for the SN visits twice a day to perform the wound care of cleanse with water, apply Bactroban ointment 2% and apply DSD (dry sterile dressing) to left upper arm. The POC orders assessment of the wound for signs and symptoms of infection. The SN visit notes dated 4/14/10 PM, 4/20/10 PM, 4/21/10 PM, 4/22/10 PM, 4/23/10 PM and 4/25/10 PM document that a "wet-dry" was applied to the wound. The SN visit notes dated 4/17/10 PM, 4/23/10 AM, 4/25/10 AM, 4/28/10 AM, 5/01/10 AM and	G 158		TN

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 7 5/02/10 PM lack documentations of assessment of The wound status and drainage. During interview with the Clinical Supervisor on 5/21/10, the Supervisor stated the use of wet to dry dressing was an error by the nurse. 3) Patient #14 has an admission date of 5/26/09 with the diagnoses including Glaucoma, Schizophrenia and Hypertension. The patient resides in an Adult Care Facility (ACF). The POC dated 1/21/2010 – 3/21/10 and 3/22/10 – 5/20/10 included orders for the SN to visit daily for application of eye drops and to "weigh client monthly and report to MD 10 lbs weight gain or loss in a month and BP (Blood Pressure) below 90/60 or above 140/90 to report to MD". The SN visit note dated 3/18/10 includes documentation of the patient's weight as "198 lbs" and "BP 150/78". The SN visit notes documents that the patient's BP exceeded the ordered BP parameters on 4/01/10 (BP 164/79), 4/10/10 (BP 160/90) and 4/11/10 (BP 180/90). The SN visit notes and the clinical record lack documentation that the SN notified the Nursing Supervisor and/or the physician regarding the changes in the patient's vital signs. During interview with the Clinical Supervisor on 5/11/10, the Supervisor did not provide an explanation for the SN failure to follow the POC for changes in the patient's vital signs. The SN visit notes lack documentation of the	G 158		TN

Amended KI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 8 Patient's monthly weight for April 2010. During interview with the Clinical Supervisor on 5/11/10, the Supervisor stated that the Home Health Aides (hha) weigh the patients and record the patient's weight on the monthly weight logs that are retained in the Adult Care Facility (ACF) in where the patient resides. 4) Patient #2 (HV) has an admission date of 7/18/06 with the diagnosis of Schizophrenia. The POC dated 2/27/10 – 4/27/10 and 4/28/10-6/26/10 documents orders for: SN visits every other week and directs "weigh patient monthly, report to MD 10lbs weigh gain or loss in one month". The SN visit notes for March 2010 lack documentation of the patients weight. On 5/10/10, a home visit was conducted at the ACF where the patient resides. An interview was conducted with the SN regarding monthly weight for the patients. The nurse stated: " we maintain monthly weight log for each patient at the ACF". The "Monthly Weight" log at the ACF documents patient's weight for 3/01/10 as 145 lbs and 4/01/10 as 160 lbs. The SN failed to notify the physician of the 15 lbs weight gain in one month. The SN visit notes lack documentation that the nurse reviewed the weight log during the patient assessments. The documentation of patient weights is on the Re-certification assessments. 5) Patient #6 (HV) has an admission date of	G 158		TN

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 9 12/14/09 with the diagnoses including Diabetes Mellitus, Schizophrenia and Hypertension. The POC dated 3/10/10 – 5/08/10 and 5/08/10-7/07/10 documents orders for SN visits every other week and directs "weigh patient monthly, report to MD 10lbs weigh gain or loss in one month". On 5/10/10, a home visit was conducted to ACF, where patient resides. An interview was conducted with the SN regarding the monthly weights for the patients, the nurse stated that we maintain monthly weight log for each patient at the ACF". The "Monthly Weight" log at ACF documents patient's weight for 2/03/10 as 201 lbs, 3/02/10 as 190 lbs, and 4/01/10 as 200lbs. The SN visit note for the month of April 2010 lack documentation of the patient's monthly weight. The "Monthly Weight" log revised 3/06 documents that the patient's weight was 200 pounds on 4/01/10, which was an increase of 10 pounds from 3/02/10. There is no documentation of physician notification regarding the 10 lbs weight gain and/or loss. The SN visit notes for April 2010 lack documentation that the nurse reviewed the weight log during the patient assessments. The documentation of patient weights is on the Re-certification assessments dated 3/08/10 and 5/04/10. Interview with the Nursing Supervisor on 5/12/10, the Nursing Supervisor stated that the nurse should " have reviewed the monthly weight log	G 158		TN

Amended XI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
	Continued from page 10 during the assessments and documented in the visit notes". 6) Patient #3 has an admission of 3/9/10 with the diagnosis of Schizophrenia. The POC dated 3/09/10 – 5/07/10 documents orders for SN visits every other month and directs "weigh patient monthly, report to MD 10 lbs weigh gain or loss in one month". The SN visit notes for the month of April 2010 lack documentation of the patient's weight. The "Monthly Weight" log revised 3/06 which are maintained in the ACF in which the patient resides documents that the patient's weight as 240 lbs on 4/01/10 and 230 lbs on 5/03/10. The SN failed to notify the physician of the 10 pounds weight loss. The SN visit notes for April 2010 lack documentation that the nurse reviewed the weight log during the patient assessments. The documentation of patient weights ls on the Initial comprehensive assessment and Re-certification assessments dated 3/09/10 and 5/04/10. 7) Patient #1 has an admission date of 2/24/05 with diagnosis of Schizophrenia. The POC of Care dated 1/29/10 – 3/29/10 and 3/30/10 – 5/28/10 document orders for SN visits every other week and directs " weigh patient monthly, report to MD 10 lbs weigh gain or loss in one month". The SN visit note dated 2/08/10-3/22/10 and 4/707/10 – 5/03/10 lack documentation of the			TN

Amended x1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

PRINTED: 05/17/2010
FORM APPROVED
OMB NO. 0938-0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A. BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 158	Continued from page 11 patient's monthly weight. On 5/11/10, survey findings were discussed with the Nursing Surpervisor, and Administrator. On 5/12/10, the Nursing Supervisor provided the surveyor with a form titled "Monthly Weight". The "Monthly Weight" log which is maintained in the ACF includes the monthly weight for this patient. There is no documentation that the nurse reviewed the "Monthly Weight" logs to ensure that the patient did not gain or loss 10 lbs in a month and that the physician was notified of any changes in the patients weight. 8) Patient #5 has admission date of 3/17/04 with diagnosis of Schizophrenia. The POC dated 4/15/10 – 6/13/10 document orders for SN visits every other week and directs "weigh patient monthly, report to MD 10 lbs weight gain or loss in one month". The SN visit notes dated 4/20/10 – 5/04/10 lack documentation of the patients weight. On 5/11/10, survey findings were discussed with The Nursing Supervisor, and Administrator. On 5/12/10, the Nursing Supervisor provided a form titled "Monthly Weight". The "Monthly Weight" log which is maintained in the ACF includes the monthly weight for this patient. There is no documentation that the nurse reviewed the "Monthly Weight" logs to ensure that the patient did not gain or loss 10 lbs in a month and that the physician was notified of any changes in the patient's weight. 9) Patient #7 (HV) has an admission date of	G 158		TP

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G158	Continued from page 12 1/26/09 with diagnosis of Schizophrenia . The POC dated 3/22/10 – 5/20/10 documents an orders for SN visits every other week and directs "weigh patient monthly, report to MD 10 lbs weigh gain or loss in one month". On 5/10/10, a home visit was conducted at the ACF where the patient resides. An interview was conducted with the SN regarding the monthly weight for the patients, the nurse stated that "we maintain monthly weight log for each patient at the ACF". The "Monthly Weight logs at ACF documents patient's weight for March 2010 as 148 lbs and May 2010 as 152 lbs. The "Monthly Weight" log lacks documentation of the patient's weight for the month of April 2010. On 5/11/10, survey findings were discussed with the Nursing Supervisor, and the Administrator. On 5/12/10, the Nursing Supervisor stated that she could not provide an explanation that the nurse reviewed the "Monthly Weight" logs to ensure that the patient did not gain or loss 10 lbs in a month and that the physician was notified of any changes in the patient's weight.	G 158		TN

Amended x1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS A Post Certification Survey was conducted on December 3, 2010 at the agency. Six (6) patient care records were reviewed (Patients # 1 through 6). One (1) deficiency resulting from the recertification survey completed on 05/12/10 remains uncorrected: G 145	G 000		
G145	484.14(g) COORDINATION OF PATIENT SERVICES A written Summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on Clinical record reviews and staff interview, the agency failed to ensure that the documentation of patient's weights on 60 day summaries. This was evident in two (2) of six (6) clinical records requiring a written 60 day summary Failure to provide accurate information on the written 60 day summary to the physician places all patients at risk for poor coordination of care. The findings are: 1) Patient #3 has a start date of care of 08/24/10 with a diagnosis of Vitamin B Complex deficiency, Chronic Obstructive Pulmonary disease, and Congestive Heart Failure. The Plan of Care (POC) dated 10/23/10 documents: SN (Skilled Nursing) one visit per month	G145	To ensure that all personnel provide a written summary report for each patient is sent to the attending physician at least every 60 days with a comprehensive review of the patient's total progress the following will take place: 1. A Nursing in-service will be conducted within Suffern and Westbury office locations to review the DOH Plan of Correction and to review Americare CSS policy and procedures to ensure that 60 day summaries meet the regulatory requirements of §482.2. A written template and sample 60 day summary will be provided. 2. A <u>100% audit of 60 day summaries in Suffern for the next quarter then 10% random audit ongoing</u>. The results of these audits will be discussed with the nurses on an individual basis, discussed monthly at the Nursing Staff meeting, reported to the QI Management meeting and to the Associate	01/19/11 Suffern & 01/20/11 in Westbury Audit to completed June 30, 2011 then on-going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	337301	A.BUILDING _____ B. WING _____	5/12/2010

AMERICARE CERTIFIED SPECIAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ROUTE 59, SUITE 102 SUFFERN, NY 10901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIENCIES (EACH DEFIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIENCY)	(X5) COMPLETION DATE
G 145	Continued from page 1 RN will perform VS (vital signs) every visit and weigh patient each certification period. The 60 day summary for the period covering 8/24/10 through 10/22/10 lacks documentation regarding the patient's vital signs and weight during this period. During the interview with the Nursing Supervisor on 12/3/10, the Supervisor did not provide an explanation. 2) Patient #5 has a start of care date of 3/3/10 with diagnosis of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Hypertension. The POC dated 9/27/10 documents: SN 3 times a day, weigh patient weekly and notify physician of weight gain/loss of 3 pounds, and assess cardiovascular system each visit. The POC dated 9/27/10 documents: "60 day summary reviewed with the physician." There is no documented summary for the previous 60 day period to include ranges of vital signs and weights. During an interview with the Nursing Supervisor on 12/30, the Supervisor stated it was "an oversight."	G 145	Administrator and Administrator in the weekly Agency Tracking & Trending Report and to the Chief Operating Officer/VP and to the Professional Advisory Board on a quarterly basis. Patient's # 3 and # 5 the 60 day summaries, vital signs and weights were discussed with the physicians and documented on a case conference note in the medical record. (see attached). However, the nurses failed to document the vital sign ranges and weights on the POC/485 which was sent/mailed to the MD for signature. To remedy the above the nurses were brought into the office, and instructed to write an addendum to the 60-day summary which has been sent to the primary physician for each patient. Each nurse received one-on-one instruction on how to write a 60 day summary, and was given a template to follow. Ongoing QI audits will be done. Results of the QI audits will be discussed with the nurses directly. If the nurses fail to document the 60 day summary correctly a performance improvement plan will be developed. If there is no improvement the nurse will be subject to disciplinary action, and continued non-compliance will result in suspension and/or termination.	12/17/10

accept to date PK 12/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation .

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 28, 2010

Selfhelp Community Services, Inc.
Attn: Madeline Jacobs
Director of Quality Management and Research
520 Eighth Avenue
New York, NY 10018

Re: Response to Plan of Correction
License: 0908L003
Survey Date: 5/27/2010

Dear Ms. Jacobs:

Please be advised that the Plan of Correction relating to the recent State Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 427-4921.

Sincerely,

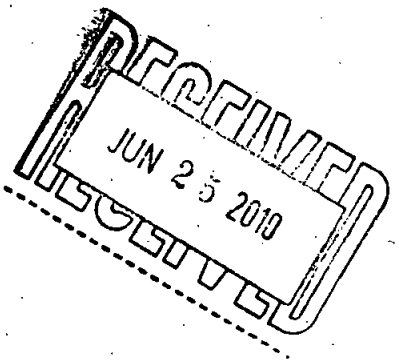
C. Phoenix-Tannis M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

Selfhelp

Selfhelp Community Services, Inc.
520 Eighth Avenue
New York, NY 10018
212.971.7600



June 25, 2010

Cheryl Phoenix-Tannis, RN, MSN, CS
Program Manager
Home Health and Hospice Services
Metropolitan Area Regional Office
90 Church Street, 13th Floor
New York, NY 10007

RE: Re-licensure Survey
License: 0908L003
Survey Date: May 27, 2010

Dear Cheryl Phoenix-Tannis:

Enclosed is the Selfhelp Licensed Home Care Service Agency Plan of Correction in response to the above mentioned survey.

Should you have any further questions, do not hesitate to contact me at 212-971-7664.

Sincerely,

Madeline Jacobs
Director of Quality Management and Research

Attachments

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0669A	A. BUILDING _____ B. WING _____	05/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES INC - NEW	520 EIGHTH AVENUE NEW YORK, NY 10018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State re-licensure survey was conducted at Selfhelp Community Services, Inc. New York on May 27, 2010. Four (4) Patient Care Records were reviewed and are identified as Patients #1 to 4. Four (4) Personnel Records were reviewed and are identified as Employees #1 to 4. The Policy and Procedure Manual, Operating License, Complaint Log, Admission Packet and Quality Improvement meeting minutes were reviewed.	H 000	Selfhelp Community Services, Inc. Licensed Home Care Agency acknowledges the full survey conducted on May 27, 2010. There were four (4) patient record reviews and four (4) personnel record reviews as identified.	
H 224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management.	H 224	I. In response to the survey findings related to patient rights, a letter of notification was created and sent out to all active patients, informing them of the correct number and address to contact New York State Department of Health for the purposes of making verbal or written complaints to the NYSDOH. II. In addition, the admission packet notification form was revised (see attached) to reflect the correct contact information for the purposes of making verbal or written complaints to the NYSDOH. III. To ensure continued compliance admission forms will be reviewed at a minimum annually by the Director of Patient Services and/or Clinical Manager. IV. All findings will be presented during the quarterly Home Care Professional Advisory Committee meeting for continued monitoring.	6/1/10 5/27/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0669A	A. BUILDING _____ B. WING _____	05/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES INC - NEW	520 EIGHTH AVENUE NEW YORK, NY 10018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 1 This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to provide patients with the correct address and phone number for lodging complaints with the New York State Department of Health (NYSDOH). This was evident for the agency's Patient Bill of Rights and Complaint/Grievance Procedure. Failure to provide the correct NYSDOH contact information for lodging complaints places patients at risk for not being able to fully exercise all rights to voice or submit a complaint. The findings are: 1) The agency "Patient Bill of Rights" lacks documented evidence of the address of the NYSDOH for reporting written complaints and documents "212-502-0700 and 212-613-4200" as the contact phone numbers for voicing complaints to the NYSDOH. The documented information are not the correct phone numbers for contacting the NYSDOH for complaints. 2) The agency "Complaint/Grievance Procedure" lacks documented evidence of the address and phone number for reporting verbal or written complaints to the NYSDOH. On May 27, 2010 at 4:06 p.m., the agency Vice President of Administration and Director of Quality Management were interviewed and did not provide an explanation.	H 224		
H 514	766.4(d) Medical orders 766.4 Medical orders.	H 514	The Director of Patient services and the Clinical Manager met with Registered Nurse and Medical Records Clerk to review the agency's	5/28/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0669A	A. BUILDING _____ B. WING _____	05/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES INC - NEW	520 EIGHTH AVENUE NEW YORK, NY 10018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 2 (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to ensure that medical orders are signed by an authorized practitioner within thirty days. This was evident for two (2) of four (4) patient care records reviewed (Patients #1 and 3). Failure to ensure medical orders are obtained and authenticated by an authorized practitioner within thirty days places all patients at risk for unauthorized care. The findings are: 1) Patient #1 has a start of care date of "7/27/07" with diagnoses which include: Coronary Artery Disease, Rectal Prolapse and Neuropathy of the Foot. The "Plan of Treatment" initiated on "6/1/08" documents the authorized physician signed and dated the order on "7/10/08". 2) Patient #3 has a start of care date of "1/29/09" with a diagnosis of Stroke.	H 514	policy on obtaining Medical order authentication by authorized practitioners within thirty (30)days of admission. All recertification to continue care must also be authorized within thirty (30) days. I. The Medical Records Clerk will conduct the following steps to ensure timely return of the authenticated medical orders: a. Mail original to authorized practitioner. b. Fax a copy to authorized practitioner followed by a phone call to confirm receipt. c. Follow-up with a phone call to authorized practitioner if authenticated order is not received within 14 days. If the above steps do not result in return of order or if authenticated order is not received within 21 days, a staff member will make arrangements to pick up medical order at authorized practitioner's office between 21 and 30 days of admission. II. In addition, all orders sent to the authorized practitioner will reference the Department of Health guidelines to encourage medical providers to return medical orders within the required time frame (see attached).	

STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0669A	A. BUILDING _____ B. WING _____	05/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES INC - NEW	520 EIGHTH AVENUE NEW YORK, NY 10018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 3 The "Plan of Treatment" initiated on "1/4/10" documents the authorized physician signed and dated the order on "3/19/10". On May 27, 2010, the Clinical Manager was interviewed and stated: "We sent it to the MD, we called them some MDs did not send it back within 30 days." PREVIOUSLY CITED 10/22/07	H 514	II. Effective immediately, monthly audits will be conducted on all medical orders from July 1, 2010 to December 31, 2010 or until compliance is achieved. IV.. Continuous internal auditing by the licensed agency's Audit Committee will report results and findings to the Corporate Compliance Committee on a quarterly basis.	
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to	H1142	I. The HPN system has been updated and all required roles have been reviewed and assigned. II. Assigned roles will be updated immediately upon any staff changes. III. An HPN coordinator will log on and review the system daily to ensure compliance. IV. To monitor compliance on an on-going basis, HPN access and updating will become a standard item on the agenda of the quarterly Home Care Professional Advisory Committee meeting.	6/24/10

New York State Department of Health

STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0669A	A. BUILDING _____ B. WING _____	05/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELFHELP COMMUNITY SERVICES INC - NEW	520 EIGHTH AVENUE NEW YORK, NY 10018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 4 requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to update the Health Provider Network (HPN) account. This was evident for the agency Communications Directory on HPN. Failure to update and keep current the HPN account places patients safety at risk during an emergent situation. The findings are: The agency HPN Communications Directory does not document assignment of the following roles : Emergency 24 by 7 facility contact; Office of the Administrator; Emergency Response Coordinator; Governing Body, Chairman/President; and Governing Body, Member. On May 27, 2010 at 3:50 pm, the Assistant Vice President Home Care was interviewed and stated: "We have tried to update it but the system is not accepting it."	H1142		

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 22, 2010

Metropolitan Jewish Licensed Home Care
Attn: Laurie Chichester, VP
6323 Seventh Avenue
Brooklyn, NY 11220

Re: Response to Plan of Correction
License: 1295L001
Survey Date: 5/6/2010

Dear Ms. Chichester:

Please be advised that the Plan of Correction relating to the recent State Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 427-4921.

Sincerely,

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State re-licensure survey was conducted at Metropolitan Jewish Licensed Home Care Services Agency on May 6, 2010. Four (4) personnel records were reviewed and are identified as Employees #1 to #4. Four (4) patient care records were reviewed and are identified as Patients #1 to #4. The Policy and Procedure Manual, Complaint Log, Admission Packet and Quality Improvement meeting minutes were reviewed.	H 000		
H 222	766.1(a)(8) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (8) voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to revise policies to include the correct phone number to contact the New York State Department of Health (NYSDOH) for complaints. This was evident for the agency Patient Rights policy and procedure.	H 222	Responsible Parties: Vice-President and Director of Patient Services Corrective action plan: The LHCSA's Patient Rights policy has been revised to include the correct contact number for complaints to the NYSDOH (attachment #1) Completion date: Done	Completed

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 222	Continued From page 1 Failure to update patient rights policies and procedures places patients at risk for not having agency staff promote and protect all patient rights. The findings is: The agency: "Attachment I: Patient Rights" document found in the agency policy and procedure manual documents the following information: "Voice complaints and recommend changes in policies and services to agency staff, the New York State Department of Health (800) 206-8125" The documented phone number ins not the correct contact information for NYSDOH complaints. On May 6, 2010 at 4:05 p.m., the agency Vice President of Home Care was interviewed and did not provide an explanation.	H 222	Responsible Parties: Vice-President and Director of Patient Services	Policies - completed. Admission agmt - N/A
H 224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such	H 224	Corrective action plan: The LHCSA's Patient Rights policy has been revised to include the correct contact number for complaints to the NYSDOH (attachment #1). The LHCSA's Patient Complaint policy regarding the investigation of and response to complaints in accordance with 766.9(j)is also available (attachment #2). For patients admitted into the LHCSA, we will utilize a 2 page Admission Agreement (attachment #3) to document that the patient has received information regarding their right to register a complaint.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 2 complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management. This Regulation is not met as evidenced by: Based on record review and interview, the agency did not provide patients with complete information for lodging complaints. This was evident for the agency admission letter. Failure to provide complete complaint information places patients at risk for not being able to fully exercise the right to make a complaint. The findings are: The agency: "admission letter" documents the following information: "To contact the Telehealth Program immediately at 718-759-4733 if you have any problems, concerns or questions about the equipment." There is no documented evidence informing patients the agency has within 15 days to explain the complaint investigation findings and the decision rendered. There is no documented evidence of informing patients of an appeals process and the appeal must be reviewed by a member or committee of the governing body within 30 days of receipt of the appeal. There is no documented evidence of informing patients the right to voice complaints and recommend changes in policies and services to	H 224	Charts for LHCSA patients will be audited monthly to ensure Admission Agreement is received back from patient. Completion date: Policies - done Use of Admission Agreement - when patients are admitted to LHCSA	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 3 agency staff, the New York State Department of Health or any outside representative of the patient's choice. On May 6, 2010 at 1:30 p.m., the agency Vice President of Home Care was interviewed and did not provide an explanation for the findings.	H 224		
H 232	766.1(c) Patient rights Section 766.1 Patient rights. (c) If a patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to have written and complete information regarding the rights of patients with diminished mental capacity to have a representative exercise all patient rights. This was evident for the agency Patient Rights policy and procedure. Failure to have a complete patient rights policy places patients at risk for not having agency staff promote and protect all patient rights. The finding is: The agency: "Patient Rights" policy and procedure lacks documented evidence of the right for patients lacking capacity to exercise the rights and the rights to be be represented by an authorized individual or guardian. On May 6, 2010 at 4:05 p.m., the agency Vice President of Home Care was interviewed and did not provide an explanation.	H 232	Responsible Parties: Vice-President and Director of Patient Services Corrective action plan: The LHCSA's Patient Rights policy has been revised to include documentation related to the rights of a patient lacking capacity in accordance with 766.1(c) (attachment #1) Completion date: Done	Completed

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From page 4	H 404		
H 404	766.3(b) Plan of care 766.3 Plan of care. The governing authority or operator shall ensure that: (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential. This Regulation is not met as evidenced by: Based on record reviews and interview the agency failed to develop complete Plans of Care. This was evident for three (3) of four (4) patient care records reviewed (Patients #1 to #3). Failure to ensure plans of care are complete places patients at risk for receiving poor care as a result of not having all needs met. The findings are: 1) Patient #1 has a start of care date of "6/10/09" ; admitted for telemonitoring of blood pressure, pulse and blood glucose. 2) Patient #2 has a start of care date of "7/13/09"; admitted for telemonitoring of blood pressure, pulse and blood glucose. 3) Patient #3 has a start of care date of "4/25/09"; admitted for telemonitoring of blood pressure, pulse and blood glucose. There is no documented evidence of Plans of Care for Patients #1, 2 and 3 which include	H 404	Responsible Parties: Vice-President and Director of Patient Services Corrective action plan: For patients admitted into the LHCSA, a 485 format will be used for physician orders (attachment #4) to ensure all pertinent information is included. Charts for LHCSA patients will be audited on a monthly basis to ensure physician orders are complete. Completion date: When patients are admitted to LHCSA	N/A

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 404	Continued From page 5 pertinent diagnosis, prognosis, mental status, medications, diet regimens, functional limitations and rehabilitation potential. On May 6, 2010 at 1:30 p.m., the agency Vice President of Home Care was interviewed and stated: "... we are providing telephonic assessments . . . we're not going into patients homes."	H 404		
H 512	766.4(c) Medical Orders 766.4 Medical orders. (c) Such orders shall be reviewed and revised as the needs of the patient dictate but no less frequently than every six months, except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid patient This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to review and revise medical orders no less frequently than every six months. This was evident for two (2) of four (4) patient care records reviewed (Patients #1 and 2). Failure to obtain medical orders every six (6) months places patients at risk for receiving unauthorized care. The findings are: 1) Patient #1 has a start of care date of "6/10/09" and was admitted for telemonitoring of blood pressure, pulse and blood glucose. The patient care record includes a medical order dated "9/29/09".	H 512	Responsible Parties: Vice-President and Director of Patient Services. Corrective action plan: For patients admitted into the LHCSA, an electronic reminder/task will be set up for 5½ months in the future to cue the Coordinator when new orders are due. This will be attached to the patient's record so if the primary Coordinator is out, the covering Coordinator will be cued to obtain the orders and nothing will be missed. Should orders require revision sooner than 6 months, they will be obtained at the time they are needed. Charts for LHCSA patients will be audited monthly to ensure orders are up to date. Completion date: When patients are admitted to LHCSA	N/A

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 512	Continued From page 6 There is no documented evidence of medical orders after "9/29/09". 2) Patient #2 has a start of care date of "7/13/09" ;admitted for telemonitoring of blood pressure, pulse and blood glucose. The patient care record includes a medical order dated "7/28/09". There is no documented evidence of medical orders after "7/28/09". On May 6, 2010 at 3:00 p.m., the Telehealth Nurse Manager was interviewed and did not provide an explanation.	H 512		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to have complete medical orders and to ensure medical orders are signed by an authorized practitioner within thirty (30) days.	H 514	Responsible Parties: Vice-President and Director of Patient Services Corrective action plan: For patients admitted into the LHCSA, a 485 format will be used for physician orders (attachment #4) to ensure all pertinent information is included. For patients admitted into the LHCSA, when the verbal order is received, the written order will be faxed the same day to the physician. The returned copy with signature will be tracked if it is not received within 3 days (5 days if it includes a weekend), the physician will be contacted again. If it is not received back in another 3-5 days, the physician will again be contacted and the order will be re-faxed. This process will be continued until the orders are received back with signature. Contact with the physician and attempts to obtain signed copies will be documented in the patient's record.	N/A

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 7 This was evident for four (4) of four (4) patient care records reviewed (Patients #1 to #4). Failure to ensure medical orders are complete and authenticated by the authorized practitioner places the patient at risk for receiving unsafe care. The findings are: 1) Patient #1 has a start of care date of "6/10/09" admitted for telemonitoring of blood pressure, pulse and blood glucose. The initial medical order dated "6/5/09" lacks documented evidence of diagnoses, medications and prognosis. 2) Patient #2 has a start of care date of "7/13/09"; admitted for telemonitoring of blood pressure, pulse and blood glucose. The initial medical order dated "6/29/09" lacks documented evidence of diagnoses, medications and prognosis. The medical order initiated on "6/29/09" was signed by the physician past 30 days on "9/22/09". The medical order initiated on "7/13/09" was signed by the physician past 30 days on "10/9/09". 3) Patient #3 has a start of care date of "4/25/09"; admitted for telemonitoring of blood pressure, pulse and blood glucose. The first documented medical orders is dated "6/10/09", which is two (2) months after the start	H 514	Charts for LHCSA patients will be audited monthly to ensure orders are up to date. Completion date: When patients are admitted to LHCSA	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 8 of care. There is no documented evidence of initial medical orders which include diagnoses, medications, treatments and prognosis. 4) Patient #4 has a start of care date of "3/12/10" and was admitted for telemonitoring of blood pressure and pulse. The initial medical order dated "3/4/10" lacks documented evidence of diagnoses, medications and prognosis. On May 6, 2010 at 3:00 p.m., the Telehealth Nurse Manager was interviewed and did not provide an explanation.	H 514		
H 720	766.6(a)(9) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (9) documentation of the patient's receipt of information regarding his/her rights. This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to document receipt of information regarding patient rights and advance directives. This was evident for four (4) of four (4) patient care records reviewed (Patients #1 to #4). Failure to document receipt of information regarding patient rights and advance directives places patients at risk for not being able to fully exercise all rights.	H 720	Responsible Parties: Vice-President and Director of Patient Services. Corrective action plan: For patients admitted into the LHCSA, we will utilize a 2 page Admission Agreement (attachment #3) to document that the patient has received information regarding their rights and advanced directives. Charts for LHCSA patients will be audited monthly to ensure Admission Agreement has been received back from patient. Completion date: When patients are admitted to LHCSA	N/A

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 720	Continued From page 9 The findings are: 1) Patient #1 has a start of care date of "6/10/09"; admitted for telemonitoring of blood pressure, pulse and blood glucose. 2) Patient #2 has a start of care date of "7/13/09" ; admitted for telemonitoring of blood pressure, pulse and blood glucose. 3) Patient #3 has a start of care date of "4/25/09" ; admitted for telemonitoring of blood pressure, pulse and blood glucose. 4) Patient #4 has a start of care date of "3/12/10"; admitted for telemonitoring of blood pressure and pulse. There is no documented evidence of receipt of information regarding patient rights and advance directives for Patient #1, 2, 3 and 4. On May 6, 2010 at 1:30 p.m., the agency Vice President of Home Care was interviewed and stated: "..... we are providing telephonic assessments . . . we're not going into patients homes."	H 720		
H1006	766.9(c) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in	H1006	Responsible Parties: Vice-President and Director of Patient Services	Completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1006	Continued From page 10 emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to develop a complete Emergency Preparedness Plan. This was evident for the agency Emergency and Disaster Preparedness policy. Failure to develop a complete Emergency Preparedness Plan places patients at risk for unsafe care during an emergency. The findings are: The agency: "Emergency and Disaster Preparedness" policy lacks documented evidence of the following information as outlined in the Dear Administrator Letter (DAL) dated "May 10, 2005": 1) Identification of a 24/7 emergency contact person and alternate to be contacted in an emergency; 2) A call down list of agency staff, contact list of community partners and collaboration with community partners in planning efforts; 3) A current patient roster containing patient demographics, rapid identification of patients, classification levels and emergency contact numbers of care-givers; 4) Documentation of participation in disaster drills; 5) How the call down list information will be kept current;	H1006	The LHCSA, a participating agency of Metropolitan Jewish Health System (MJHS) abides by the MJHS System Emergency Management Plan. The Plan applies to patients admitted within the LHCSA. The Emergency Management Plan Policy is further detailed in the Emergency Management Manual. The Emergency Management Manual is updated annually. The Plan which is evidence of operational preparedness includes procedures to follow to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services. The Plan for Emergency Preparedness/ Management addresses the following: #1: Attachment #5: Page 2 of emergencyManagement Policy(Identification of 24/7 emergency contact person and alternate) Page 2 of Emergency Management Manual Identification of 24/7 emergency contact person and alternate) #2: Attachment #6: Call Down List Pages 8,9, 11-16 from Emergency Management Manual (Contact list of community partners and HPN Policy) Page 1 from Emergency Management Manual (Collaboration with community partners in planning effort) #3: Attachment #7: Attached copy of Emergency Classification Guidelines and procedure from 12/09 and Patient Classification System used prior to 12/09 (Classifications from the Emergency Management Manual and Policy). #4. Attachment #8: Actual Events in which Emergency Management Plan activities implemented Disaster drill for IT which impacts upon electronic data collection and medical record Home Based Care Task Force Meetings with OEM- evidence of continuous participation by MJHS leadership #5. Human Resources maintains list of employees which is kept current. Human Resource updates files with new employee demographics upon hire and upon termination of employment. This list is constantly maintained and made available to the VP and Director. The Director updates the call down list whenever there are agency staffing changes.	

ew York State Department of Health

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1006	Continued From page 11 6) Annual review and update of the plan and orientation of staff. On May 6, 2010 at 4:07 p.m., the agency Vice President of Home Care was interviewed and did not provide an explanation.	H1006	#6. Attachment #9: Page 3 & 4 of the Emergency Management Policy (Annual review and update, orientation of staff). Completion date: Done	
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health;	H1142	Responsible Parties: Vice-President and Director of Patient Services Corrective action plan: The Director of Patient Services had been erroneously set up in the HPN as an Administrator. His role has since been corrected in the Directory. The staff person in the role of Emergency Response Coordinator performs that role for multiple agencies within Metropolitan Jewish Health System and shares pertinent information across the system. As such, her access had been granted through another MJHS agency however, she has since been assigned to this role directly in the LHCSA. We are awaiting the signed paperwork from the Governing Board Chairman and will submit his HPN access application by June 9, 2010 The LHCSA has a self perpetuating Board and does not have members, therefore assignment of a Governing Body, Member in HPN does not apply. Completion date: June 9, 2010	7/9/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0523A	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN JEWISH LICENSED HOME C/	6323 SEVENTH AVENUE BROOKLYN, NY 11220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 12 (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to maintain a current Health Provider Network (HPN) Communications Directory. Failure to ensure the HPN Communications Directory is current places patients at risk for unsafe care during an emergent situation. The findings are: A copy of the agency "Contact Information" from the HPN Communications directory was provided. The following roles were unassigned in the communications directory: Director, Home Care Patient Services; Emergency Response Coordinator; Governing Body, Chairman/President and Governing Body, Member. On May 6, 2010, the agency Vice President of Home Care was interviewed but did not provide an explanation.	H1142		

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

August 2, 2010

Metrocare Givers Inc.
Attn: Camille M. Singer, RN
Director of Patient Services
325 Gold Street, 3rd Floor
Brooklyn, NY 11201

Re: Response to Plan of Correction
Provider: #9773L001
Survey Date: 6/9/2010

Dear Ms. Singer:

Please be advised that the Plan of Correction relating to the recent State Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 427-4921.

Sincerely,

C. Phoenix-Tannis MN P

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPL DAT
H 000	Initial Comments A State re-licensure survey was conducted at Metro Care Givers, Inc. on June 9, 2010. Five (5) Patient Care Records were reviewed and are identified as Patients #1 to 5. Six (6) Personnel Records were reviewed and are identified as Employees #1 to 6. The agency Policy and Procedure Manual, Complaint Log and Quality Improvement Committee Meeting Minutes were reviewed.	H 000		
H 614	766.5(b)(1) Clinical supervision 766.5 Clinical supervision. The governing authority shall ensure for all health care services that: (b) all staff delivering care in patient homes are adequately supervised. The department shall consider the following factors as evidence of adequate supervision: (1) staff regularly provide services at the times and frequencies specified in the patient's plan of care and in accordance with the policies and procedures of their respective services. This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to ensure patients receive services according to the frequency on the Plan of Treatment. This was evident for two (2) of five (5) patient care records reviewed (Patients #1 and 2). Failure to provide services as ordered in the Plan of Treatment places patients at risk for receiving poor care and unsafe care.	H 614	766.5 (b)(1) Clinical Supervision The DPS reviewed the records of the two patients (patients #1 & 2) to ensure current visits were completed. Patient # 1 was last seen on 4/19/2010 with the next visit due on 7/19/2010. Patient #2 was last seen on 5/10/2010 with the next visit due on 8/10/2010. Responsible person: DPS Complete Date: 6/10/2010 All existing patient records were reviewed for visit frequency to maintain that visits were current, and the next visit & aide supervision was scheduled according to the Plan of Care. 100% of the existing patient visits were found to be current as of 6/15/2010, and the next visits including aide supervisions were scheduled according to the patient's Plan of Care. Responsible person: DPS Complete Date: 6/15/2010 An additional Registered Nurse was hired on 5/18/2010 to assist with patient visits and aide supervisions. The DPS reviewed the process for scheduling and tracking visits. The DPS in-serviced the nursing staff in the process for scheduling and tracking visits. The DPS will review the patient visit schedules on a daily basis to ensure nursing visits and aide supervisions are assigned and completed according to the Plan of Care. Responsible person: DPS Complete Date: 7/8/2010 The DPS will perform a quarterly audit of 100% of all patient records on a quarterly basis to ensure services are provided according to the Plan of Care. The results will be reported to the Quality Assurance Committee on a quarterly basis and forwarded to the Governing Authority. Responsible person: DPS Complete Date: 9/29/2019 (date of next PI), and ongoing	

Camille M. Singer RN/DPS

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DA

7/15/10

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 614	Continued From page 1 The findings are: 1) Patient #1 has a start of care date of "6/2/09" with diagnoses which include: Parkinson's Disease and Glaucoma. The agency: "Plan of Treatment" dated "12/2/09 to 6/2/10" documents: "RN (Registered Nurse): Every 3 months for patient reassessment, aide teaching and supervision" The patient care record documents nursing visits and aide supervision on "11/30/09" and "4/19/10". The nursing visits and aide supervision are not completed every 3 months as ordered on the Plan of Treatment. 2) Patient #2 has a start of care date of "12/3/09" with diagnoses which include: Insulin Dependent Diabetes Mellitus, Hypertension, Glaucoma. The agency: "Plan of Treatment" dated "12/3/09 to 6/3/10" documents the following information: "RN (Registered Nurse): Every 3 months for patient reassessment, aide teaching and supervision" The patient care record documents nursing visits and aide supervision on "12/3/09" and "5/7/10". The nursing visits and aide supervision are not completed every 3 months as ordered on the Plan of Treatment. On June 9, 2010 at 11:56 a.m., the agency Director of Patient Services was interviewed and stated: "I know . . . that's why we hired someone else."	H 614		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPL DAT
H1006	766.9(c) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan. This Regulation is not met as evidenced by: Based on record review and interview, the Governing Authority failed to revise the agency's Emergency Operation Plan. Failure to have an updated Emergency Operation Plan places patients at risk for unsafe care during an emergency situation. The findings are: 1) There is no documented evidence of a patient roster containing patient demographics and priority classification levels (Levels 1, 2 and 3) to facilitate rapid identification of patients and the emergency contact numbers of care givers for current patients. 2) There is no documented evidence of agency collaboration with community partners in planning efforts. 3) There is no documented evidence of a current call-down list of agency staff and the procedure to maintain the call-down list.	H1006	766.9(c) Governing Authority The agency's patient roster was updated to include patient demographics and priority classification levels. The agency's staff roster was updated. Both current patient and staff rosters were printed and made available to the office staff and a copy filed in the on-call binder on 7/2/2010. The agency call-down list was updated with current employees and all their contact information on 6/10/2010. The DPS is completing the Emergency Operations Resource List to include the names and phone numbers of all the agency's community resources including the agency's community partners. Responsible person DPS Complete Date: 7/15/2010 A process was developed and implemented to ensure a current Emergency Operations Plan. The patient and staff rosters will be updated on a weekly basis, printed, made available to the office staff and a copy will be filed in the on call binder. The call-down list will be reviewed minimally on a quarterly basis but updated as an employee's status changes. The Emergency Operations Resource List will be maintained by the DPS and a copy kept in all office sites as well as in the on-call book. Responsible person DPS Complete Date: 7/8/2010 & ongoing All agency staff will be in-serviced in the process and their responsibility in updating patient & staff rosters, the call-down list and the Emergency Operations Resource List. Responsible person: DPS Complete Date: 7/8/10 The DPS will perform a quarterly audit of the Emergency Operations Plan to ensure that patient & staff rosters, the call down list and Emergency Operations Resource List are current and up to date. The results will be reported to the Quality Assurance Committee on a quarterly basis and forwarded to the Governing Authority. Responsible person: DPS Complete Date: 9/29/2019 (date of next PI), and ongoing	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPL DAT
H1006	Continued From page 3 The agency call-down list of agency staff documents the name of a nurse not currently employed with the agency. The agency call-down list of agency staff documents the name of a nurse hired by the agency on "5/18/2010". There is no documentation of the nurse's phone number. The agency contact list of Home Health Aides and Personal Care Aide's included in the Emergency Operation Plan documents a print out date of "September 19, 2008". 4) There is no documented evidence of a contact list of community partners as documented in the agency "Emergency Operation Plan" and the procedure to maintain the contact list. The agency "Emergency Operation Plan" documents: "A readily accessible and current Emergency Operations Resource List with name and telephone and includes: fire, police, Red Cross, area emergency relief services, will be maintained at all office sites, and in the on-call book." There is no documentation of the "Emergency Operations Resource List". On June 9, 2010 at 3:20 p.m., the agency Director of Patient Services was interviewed and did not provide an explanation.	H1006		
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority	H1142	766.9(o) Governing Authority The agency administrator reviewed the staff users of the agency's HPN account. Roles were clarified and an additional person was assigned as coordinator. The HPN Communications Directory was updated to reflect the current assignments. Responsible person Administrator Complete Date: 7/6/2010	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X COMI DA
H1142	Continued From page 4 or operator of an agency shall obtain from the Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to maintain a current Health Provider	H1142	The agency administrator reviewed the agency's HPN policy and updated it to ensure that the HPN Communications Directory is maintained and changed, as roles are assigned/re-assigned. A log will be maintained by the HPN coordinator to reflect review of the HPN Communications Directory minimally on a monthly basis, and changes as they occur. Responsible person Administrator Complete Date: 7/6/2010 All agency staff were in-serviced in the updated HPN policy, and their role in the HPN & maintenance of the HPN Communications Directory. Responsible person: Administrator Complete Date: 7/6/10 The Administrator will perform a quarterly audit of the HPN Communications Directory and the log to ensure that the directory is current and changes are made as they occur. The results will be reported to the Quality Assurance Committee on a quarterly basis and forwarded to the Governing Authority. Responsible person: Administrator Complete Date: 9/29/2019 (date of next PI), and ongoing	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/201(

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X COMI DA
H1142	Continued From page 5 Network (HPN) Communications Directory. Failure to ensure the HPN Communications Directory is current places patients at risk for unsafe care during an emergent situation. The findings is: The agency HPN Communications Directory documents the following roles as unassigned: Director, Home Care Patient Services and Governing Body, Chairman/President. The Director of Patient Services (DPS) was interviewed and did not provide an explanation.	H1142		
H1338	766.11(g) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (g) that personnel records include verifications of employment history and qualifications for the duties assigned and, as appropriate, signed and dated applications for employment; records of professional licenses and registrations; records of physical examinations and health status assessments; performance evaluations; dates of employment, resignations, dismissals, and other pertinent data provided that all documentation and information pertaining to an employee's medical condition or health status, including such records of physical examinations and health status assessment shall be maintained separate and apart from the non-medical personnel record information and shall be afforded the same confidential treatment given patient medical records under section 766.6 of this Part.	H1338	766.11 (g) Personnel The employee (employee #1) was removed from direct patient care until an annual health assessment and Mantoux/PPD are completd, which began 7/6/10 and which will be completed by 7/8/2010 when the Mantoux/PPD testing is read. Employee # 1 was scheduled for in-home observation visit on 6/8/2010. Patients seen by this employee were observed and monitored for signs & symptoms of TB. The patients have remained free from signs & symptoms of TB and will continue to be monitored. Documentation for this in-home observation was located and filed in the employee's personal file. An overall assessment of performance was completed on 7/7/2010 and filed in the employee's record. The employee (employee #2) was removed from direct patient care until two (2) reference checks were verified which was completed by 7/8/2010. Responsible person: DPS Complete Date: 7/8/2010 The DPS will perform an audit of 100% of the employees' records to	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
H1338	Continued From page 6 This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to maintain complete personnel records. This was evident for two (2) of five (5) personnel records reviewed (Employees #1 and 2). Failure to maintain complete personnel records places patients at risk for receiving care from potentially unqualified employees. The findings are: 1) Employee #1 is a Registered Nurse hired by the agency on "5/6/02". There is no documented evidence of an annual health assessment and Mantoux/PPD testing for the year 2008. There is no documented evidence of an in-home observation for the year 2008. There is no documented evidence of an annual evaluation and in-home observation for the year 2009. 2) Employee #2 is a Registered Nurse hired by the agency on "5/18/10". There is no documented evidence of two (2) verified reference checks. On June 9, 2010 at 1:50 p.m., the agency Director of Patient Services was interviewed and did not provide an explanation. Previously cited 10/24/07.	H1338	ensure complete personnel records are maintained including two (2) verified reference checks, an annual performance assessment, annual in home supervisory visits to observe performance, and annual health assessments & Mantoux/PPD. The health records are maintained in a separate folder apart from the personnel record. All non-compliant employees will be removed from direct patient care until all-missing components are scheduled, completed and filed in the employee's personnel record. Responsible person DPS Complete Date: 7/15/2010 The DPS reviewed the agency's policy and process for ensuring compliance with verification of reference checks, annual assessments including the in-home supervisory visit and annual health assessments & Mantoux/PPDs. The scheduling and tracking process was also reviewed. The DPS in-serviced all agency staff in the agency's process for scheduling and tracking personal compliance. Responsible person: DPS Complete Date: 7/8/10 The DPS will perform a quarterly audit of 100% of all personnel records for one-year, then quarterly audit of 25% of all personnel records thereafter. The results will be reported to the Quality Assurance Committee on a quarterly basis and forwarded to the Governing Authority. Responsible person: DPS Complete Date: 9/29/2010 (date of next PI), and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPL DAT
H1342	Continued From page 7	H1342		
H1342	766.11(i) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (i) that all personnel receive orientation to the policies and procedures of the home care services agency operation and in-service education necessary to perform his/her responsibilities. At a minimum: (1) home health aides must participate in 12 hours of in-service education per year; and (2) personal care aides must participate in six hours of in-service education per year. This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to document orientation to agency policy and procedures; specific duties; emergency disaster plan and required annual training for employees. This was evident for two (2) of six (6) personnel records reviewed (Employees #1 and 2). Failure to document required orientation and annual training for employees places patients at risk for receiving poor care from potentially unqualified personnel. The findings are: 1) Employee #1 is a Registered Nurse hired by the agency on "5/6/02" There is no documented evidence of annual Universal Precautions training for the years 2008 and 2009.	H1342	766.11(l)(1) Personnel The employee (employee #1) was scheduled for and attended in-services on Standard Precautions and HIV confidentiality on 12/18/2008 and again on 12/29/2009. Documentation of attendance at these inservices was located and filed in the employee's personal file on 6/10/2010. The employee (employee #2) was a new employee and still in orientation at the time of the survey. This employee completed the agency's orientation including orientation to the agency's policy and procedures, specific duties, the agency's emergency operations plan, HIV Confidentiality and Standard Precautions on 6/10/2010. Evidence of completion of the orientation was filed in the employee's personal file on 6/10/2010. Responsible person: DPS Complete Date: 6/10/2010. The DPS will perform an audit of 100% of the employee's records to ensure compliance to orientation	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0718A	A. BUILDING _____ B. WING _____	06/09/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROCARE GIVERS INC	325 GOLD STREET, 3RD FLOOR BROOKLYN, NY 11201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CO
H1342	Continued From page 8 2) Employee #2 is a Registered Nurse hired by the agency on "5/18/10". There is no documented evidence of orientation to agency policy and procedures, specific duties and emergency disaster plan. There is no documented evidence of HIV Confidentiality training and Universal Precautions training at the time of hire. On June 9, 2010 at 1:50 p.m., the agency Director of Patient Services was interviewed and did not provide an explanation.	H1342	and attendance at an in-service on Standard Precautions and HIV confidentiality at the time of hire and on an annual basis. All non-compliant employees will be removed from direct patient care until the employee attends orientation and an inservice on Standard Precautions & HIV confidentiality, and proof of attendance is filed the employee's personnel record. In-services are scheduled every Tuesday for the remainder of 2010. Responsible person: DPS Complete Date: 7/15/2010. The DPS reviewed the agency's policy and process for ensuring compliance with initial orientation and Standard Precautions & HIV confidentiality in-services. The DPS in-serviced all agency staff in agency's policy and process for scheduling and tracking initial orientation and Standard Precautions & HIV confidentiality in-services. Responsible person: DPS Complete Date: 7/8/2010 The DPS will perform a quarterly audit of 100% of all new personnel records for compliance to initial orientation and Standard Precautions & HIV confidentiality in-services. The results will be reported to the Quality Assurance Committee on a quarterly basis and forwarded to the Governing Authority. Responsible person: DPS Complete Date: 9/29/2010 (date of next PI), and ongoing	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

August 25, 2010

Premier Home Health Care Services, Inc.
Attn: Donna Duggan, RN
Director of Clinical Services
9202 Fifth Avenue
Brooklyn, NY 11209

Re: Response to Plan of Correction
License: 1665L003
Survey Date: 6/10/2010

Dear Ms. Duggan:

Please be advised that the Plan of Correction relating to the recent State Re-licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 417-4921.

Sincerely,

C. Phoenix-Tannis, M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES INC	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State re-licensure survey was conducted at "Premier Home Health Care Services, Inc". (1665L003) (formerly known as Patient Care1147L003) on June 10, 2010. Four (4) Patient Care Records were reviewed and are identified as Patients #1 to 4. Seven (7) Personnel Records were reviewed and are identified as Employees #1 to 7. The agency Policy and Procedure Manual, Complaint Log and Quality Improvement Committee Meeting Minutes were reviewed.	H 000		
H 514	766.4(d) Medical orders 766.4 Medical orders. (d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, and other pertinent patient information relevant to the agency plan of care; and (1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and (2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within thirty (30) days. This Regulation is not met as evidenced by: Based on record reviews and interview, the agency failed to ensure medical orders are signed within 30 days by an authorized practitioner. This was evident for two (2) of four (4) patient care records reviewed (Patients #1 and #2).	H 514	**H514** **I. Corrective action for those patients found to be affected by the deficient practice:** **1. Patient#1 FNS was reeducated on obtaining signed and dated MD orders within 30 days as per agency policy and state regulations.** **2. Patient #2 FNS was reeducated on obtaining signed MD orders as per agency policy and state regulations.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed cases have the potential to be affected by the deficient practice.** **1. The agency will perform 100% audit of the current population of case managed cases**	9/30/2010

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 514	Continued From page 1 Failure to ensure medical orders are signed within 30 days places patients at risk for unsafe and unauthorized care. The findings are: 1) Patient #1 has a start of care date of "8/14/08" and a diagnosis of Hypertension. The patient care record documents a medical order initiated on "10/16/09" and signed by the authorized practitioner on "11/19/09". 2) Patient #2 has a start of care date of "11/28/08" and a diagnosis of Hypertension. The patient care record documents medical orders initiated on "03/05/09", "09/05/09" and "03/05/10". There is no documented evidence of the date the physician signed the orders. On June 10, 2010 at 4:50 p.m., the Director of Patient Services was interviewed and stated: "I can't get the MD's signatures." Previously cited on 11/08/07.	H 514	**III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **1. The Regional Director of Patient Services will be responsible for overseeing the audit process and then the Office Administrator moving forward.** **2. FNS's re-educated on completion of POT, inclusive of identification of services provided, diagnoses matching medications, and procedures for obtaining signed MD orders within 30 days as per agency policy and state regulations.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **As is company practice, random quarterly chart audit will continue to ensure compliance with completion of plan of treatment and MD signature within 30 days.** **Persons responsible for ongoing compliance:** **1. FNS** **2. RDPS** **3. Office Administrator**	9/30/2010
H1010	766.9(e) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (e) make available to the public information concerning the services which it offers, the	H1010		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1010	Continued From page 2 geographic area in which these services are made available, the charges for the various types of service and the payment mechanisms which may be available for such services. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to provide the public with correct information about the services which it offers. This was evident for the agency admission packet and "Scope of Services" policy and procedure. Failure to provide the public with accurate information places patients at risk for receiving services that are not authorized. The findings are: The agency operating license documents the agency is authorized to provide the following services: "Nursing, Home Health Aide, Personal Care, Homemaker and Housekeeper ". The agency: "Consent for Treatment" form included in the admission packet documents the following information: ".... Services which may be rendered by ...physical therapists " . The agency is not authorized to provide Physical Therapy. The agency: "Client Service Agreement" form included in the admission packet documents the following services: "Companion" and "Escort". The agency: "Scope of Services" policy and procedure documents the agency offers "Companion " services. The agency is not authorized to provide	H1010	H1010 I. Corrective action for those patients found to be affected by the deficient practice: No patients were affected by the deficient practice 1. Consent for treatment forms will be amended to exclude physical therapy services. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All case managed cases have the potential to be affected by this deficient practice 1. Consent for treatment forms will be amended to exclude physical therapy services. III. Measures that will be put in place to ensure that the deficient practice will not reoccur: 1. Upon receipt of amended form, all admission packets will be updated with new form that states accurately authorized services. 2. All staff will be educated on new form	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN(	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1010	Continued From page 3 "Companion" and "Escort" services. On June 10, 2010 at 5:55 pm, the Director of Patient Services was interviewed and did not provide an explanation.	H1010		
H1020	766.9(j) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (j) ensure the development and implementation of a patient complaint procedure to include: (1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received by the agency; (2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint; (i) explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and (ii) advising the complainant of the right to appeal the outcome of the agency's complaint investigation and the appeal procedure to be followed; (3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal; and	H1020	IV. **How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **Quarterly audits will be conducted to ensure compliance and reviewed at the quarterly QI meetings** **Persons responsible:** **1. FNS** **2 Branch Administrator** **3 RDPS** **4 Director of Clinical Services** **H1020** **I. Corrective action for those patients found to be affected by the deficient practice:** **No patients were affected by the deficient practice.** **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** **All case managed patients have the potential to be affected by this deficient practice.** **1. Complaint logs will be reviewed to ensure that all complaints have been resolved. The log will be updated to reflect date of resolution.**	9/30/2010 9/30/2010

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1020	Continued From page 4 (4) notification to the patient or his or her designee that if the patient is not satisfied by the agency's response, the patient may complain to the Department of Health's Office of Health Systems Management. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to maintain a log to document the receipt, investigation and resolution of complaints. This was evident for the agency complaint log. Failure to maintain a complaint log places patients at risk for poor care as a result of the agency not responding to complaints in a timely manner. The findings are: The agency complaint log documents complaints received on "02/08/10" " 03/02/10", "11/11/09", "11/02/09", "11/19/09", "11/30/09" and 07/13/09". There is no documented evidence of the dates of resolution for the complaints. On June 10, 2010 at 5:52 p.m., the Director of Patient Services was interviewed and did not provide an explanation. Previously cited on 11/08/07.	H1020	**III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** **1. All staff will be in serviced on proper completion of complaint logs, including date of resolution, as per agency policy and procedure.** **2. Office Administrator/Operations Manager will review logs weekly to ensure that resolution has been obtained and documented.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** **As is company practice, complaint logs will be reviewed at quarterly branch QI meetings to ensure that complaints are reported and resolved timely.** **Persons responsible for ongoing compliance** **1. FNS** **2. Office Administrator** **3. Regional DPS**	9/30/2010
H1142	766.9(o) Governing Authority Section 766.9 Governing authority (o) Health Provider Network Access and Reporting Requirements. The governing authority or operator of an agency shall obtain from the	H1142		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 5 Department ' s Health Provider Network (HPN), HPN accounts for each agency that it operates and ensure that sufficient, knowledgeable staff will be available to and shall maintain and keep current such accounts. At a minimum, twenty-four hour, seven-day a week contacts for emergency communication and alerts, must be designated by each agency in the HPN Communications Directory. A policy defining the agency ' s HPN coverage consistent with the agency ' s hours of operation shall be created and reviewed by the agency no less than annually. Maintenance of each agency ' s HPN accounts shall consist of, but not be limited to, the following: (1) sufficient designation of the agency ' s HPN coordinator(s) to allow for HPN individual user application; (2) designation by the governing authority or operator of an agency of sufficient staff users of the HPN accounts to ensure rapid response to requests for information by the State and/or local Department of Health; (3) adherence to the requirements of the HPN user contract; and (4) current and complete updates of the Communications Directory reflecting changes that include, but are not limited to, general information and personnel role changes as soon as they occur, and at a minimum, on a monthly basis. This Regulation is not met as evidenced by: Based on record review and interview, the governing authority failed to maintain a current Health Provider Network (HPN) Communications	H1142	H1142 **I. Corrective action for those patients found to be affected by the deficient practice:** There were no patients found to be affected by this regulation. **II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken:** 1. The agency policy and procedure defines the necessary roles within the organization and the function of the HPN coordinator. 2. As is agency practice, the policies and procedures are reviewed annually. 3. Designated employees will be assigned to the role of: 24/7 Facility Contact, Office of the Administrator, Criminal History Record Check authorized person, Governing Body Chairman/President, Governing Body member. **III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. As is agency practice, the policies and procedures are reviewed annually. 2. An audit of the HPN system will be conducted to ensure current accurate information regarding role designation of employees and reviewed as an agenda item at the quarterly Corporate QI meeting.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1142	Continued From page 6 Directory. Failure to have an HPN account for each agency and have staff to maintain a current HPN Communications Directory places patients at risk for unsafe care during an emergent situation. The findings are: On June 10, 2010 at 4:00 p.m., a computer print out of the agency HPN Communications Directory was provided for review. The following roles are unassigned: "24 by 7 Facility Contact" and "Office of the Administrator". On June 10, 2010 at 4:58 p.m., the Director of Patient Services was interviewed and did not provide an explanation.	H1142	IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur? Quarterly audits will be conducted to ensure compliance and reviewed at the quarterly QI meetings Persons responsible: 1. FNS 2 Branch Administrator 3 RDPS 4 Director of Clinical Services	9/30/2010
H1342	766.11(i) Personnel 766.11 Personnel. The governing authority or operator shall ensure for all health care personnel: (i) that all personnel receive orientation to the policies and procedures of the home care services agency operation and in-service education necessary to perform his/her responsibilities. At a minimum: (1) home health aides must participate in 12 hours of in-service education per year; and (2) personal care aides must participate in six hours of in-service education per year. This Regulation is not met as evidenced by:	H1342	H1342 I. Corrective action for those patients found to be affected by the deficient practice: There were no patients found to be affected by the deficient practice. II. Identification of other patients having the potential to be affected by the deficiency and what corrective action will be taken: All patients have the potential to be affected by the deficient practice. 1. The agency policy and procedure requires that all employees receive annnal HIV confidentiality to ensure there is no breach in confidentiality. 2. The agency policy requires all employees receive annual training in universal precautions to reduce the risk of exposure to and transmission of infections.	

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC0681D	A. BUILDING _____ B. WING _____	06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME HEALTH CARE SERVICES IN	9202 5TH AVE BROOKLYN, NY 11209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H1342	Continued From page 7 Based on record review and interview the agency failed to ensure employees receive HIV Confidentiality and Universal Precautions training annually. This was evident for two (2) of seven (7) personnel records reviewed (Employees #6 and 7). Failure to ensure annual training in HIV Confidentiality and Universal Precautions places employees and patients at risk for breach of confidential information and exposure to infection. The findings are: 1) Employee #6 is a Registered Nurse hired by the agency on "12/04/07". There is no documented evidence of annual HIV Confidentiality and Universal Precautions training for the years 2008 and 2009. On June 10, 2010, at 5:06 p.m., the Director of Patient Services was interviewed and stated: "Per the HR (Human Resources) Coordinator, the HIV Confidentiality and Universal Precautions training is not present in the file." 2) Employee #7 is a Registered Nurse and Director of Patient Services hired by the agency on "11/14/07". There is no documented evidence of annual HIV Confidentiality and Universal Precautions training for the year 2008. On June 10, 2010 at 4:45 p.m., the Director of Patient Services was interviewed and did not provide an explanation.	H1342	**III. Measures that will be put in place to ensure that the deficient practice will not reoccur:** 1. **The Office Administrator will monitor that all staff attend annual mandatory training.** 2. **Evidence of attendance will be documented and placed in the employee file.** **IV. How will the corrective action be monitored to ensure the deficient practice will not reoccur?** 1. **The agency will document annual HIV confidentiality and universal precautions training on all employees as per agency policy and state regulation.** 2. **Documentation of training will be placed in the employee record.** 3. **Compliance reports will be reviewed monthly to ensure compliance with agency policy and SDOH regulation.** 4. **Persons responsible for ongoiug compliance:** **1. Office Administrator** **2. FNS** **3. RDPS** **4. Compliance supervisor**	9/30/2010

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Metropolitan Area Regional Office 90 Church Street, New York, NY 10007

Richard F. Daines M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

August 25, 2010

Americare of New York City
Attn: Nancy Hahn
Administrator
3044 Coney Island Avenue
Brooklyn, NY 11235

Re: Response to Plan of Correction
License: 9190L001
Survey Date: 7/15/2010

Dear Ms. Hahn:

Please be advised that the Plan of Correction relating to the recent State Re-Licensure Survey of your agency have been reviewed by this office.

All items were found to be acceptable and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies.

If you have any questions regarding this matter, please call our office at (212) 417-4921.

Sincerely,

C. Phoenix-Tannis, M.P.

Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
Bureau of Home Health Care and Hospices Services
Metropolitan Area Regional Offices

/jt

americare®
a tradition of caring

August 6, 2010

Ms. Cheryl Phoenix-Tannis, RN, MSN, CS
Regional Program Director
New York State Department of Health
Home Health Care and Hospice Services
Metropolitan Area Regional Office
90 Church Street
New York, New York 10007

Re: Re-Licensure Survey
License: 9190L001
Survey Date: July 15, 2010

Dear Ms. Phoenix-Tannis:

Please find enclosed Americare Inc.'s Plans of Correction in response to the Statements of Deficiency issued by your office dated July 30, 2010 resulting from the re-licensure survey of our agency conducted on July 15, 2010.

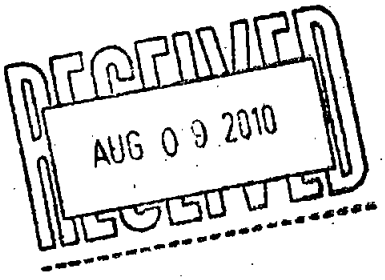
Should you have questions, please contact me at 718-434-5100 extension 3114.

Thank you.

Sincerely,

Nancy Hahn

Nancy Hahn
Administrator



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments A State re-licensure survey was conducted at Americare of New York City on July 15, 2010. Five (5) Patient Care Records were reviewed and are identified as Patients #1 to 5. Five (5) Personnel Records were reviewed and are identified as Employees #1 to 5. The agency Policy and Procedure Manual, Complaint Log and Quality Improvement Committee Meeting Minutes were reviewed.	H 000		
H 224	766.1(a)(9) Patient rights Section 766.1 Patient rights. (a) The governing authority shall establish written policies regarding the rights of the patient and shall ensure the development of procedures implementing such policies. These rights, policies and procedures shall afford each patient the right to: (9) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions of subdivision (j) of section 766.9 of this Part. The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Health's Office of Health Systems Management. This Regulation is not met as evidenced by: Based on record review and interview, the agency	H 224		

RECEIVED
AUG 09 2010
DOH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
H 224	Continued From page 1 did not provide patients complete information about the agency procedures for investigating complaints. This was evident for the agency "Complaint Procedure" included in the admission Packet. Failure to provide patients complete written complaint information places patients at risk for not being able to fully exercise rights. The findings are: 1) There is no documented evidence of informing patients the agency has within 15 days to explain the complaint investigation findings and the decision rendered. 2) There is no documented evidence of informing patients of an appeals process and the appeal must be reviewed by a member or committee of the governing body within 30 days of receipt of the appeal. On July 15, 2010 at 4:30 pm., the agency Director of Patient Services and Administrator were interviewed and did not provide an explanation.	H 224	Plan for Allegedly Affected Patients: The Director of Patient Services will assign a Nurse to re-visit patients #1, #2, #3 to explain and provide each a copy of Americare Inc.'s revised Complaint Procedure outlined in the Patient Bill of Rights. **(attachment #1)** Plan to Identify other Potentially Affected Patients: The Director of Patient Services will send all current patients the following documents 1. Cover Letter **(attachment #2)** 2. Amended Patient Bill of Rights 3. Acknowledgment of Receipt **(attachment #3)** Measures and Systems The Director of Patient Services will meet with all the nurses to: 1. Review Americare Inc.'s existing "Patient Grievance Complaint Procedure." **(attachment #4)** 2. Review the amended Patient Bill of Rights 3. Review the nurses' responsibility in ensuring that the amended Bill of Rights is included in the admission packet before given to patients 4. Review the nurses' responsibility in ensuring Patient Rights are fully explained to patient and or their representatives.	8/9/2010 8/9/2010 8/11/2010
H 722	766.6(a)(10) Patient care record 766.6 Patient care record. (a) The agency shall maintain a confidential record for each patient admitted to care to include: (10) a discharge summary when the patient is discharged from the agency including: (i) documentation of discharge planning	H 722	Monitoring Systems A dedicated staff will be assigned to randomly check 20 admission folders per month to ensure that revised and updated Patient Bill of Rights is included in the folder. Newly admitted patients will be contacted by their assigned coordinators to ensure they have received the Patient Bill of Rights. Information obtained from monitoring of admission folders and patient contact will be prepared and provided at the Professional Advisory Committee Meeting every quarter.	8/9/2010 On-going 8/9/2010 On-going 9/8/2010 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
H 722	Continued From page 2 preparation; (ii) notification to the patient's authorized practitioner; (iii) reasons for discharge and date of discharge; (iv) summary of care given and patient's progress; (v) patient status upon discharge including a description of any remaining needs for patient care and supportive services; (vi) patient or family ability to self-manage in relation to any remaining problems; and (vii) recommendations and referral for any follow-up care, if needed. This Regulation is not met as evidenced by: Based on record reviews and interview, the agency did not document a discharge summary, including notifying the authorized practitioner, when patients are discharged from the agency. This was evident for two (2) of two (2) discharged patient care records reviewed (Patients #4 and 5). Failure to document a discharge summary places patients at risk for potentially unsafe and poor continuity of care. The findings are: 1) Patient #4 has a start of care date of "11/25/09" and a discharge date of "6/26/10". There is no documented evidence of a discharge summary and notification to the patient's authorized practitioner.	H 722	Plan for Allegedly Affected Patients The Director of Patient Services will contact patients #4 and #5 to determine and identify whether they have remaining health care needs and or any follow-up/ referral needs, and whether their physicians have been informed of their discharge from Americare Inc. Should these patients request assistance with referral or with any remaining needs, The Director of Patient Services will assist them as appropriate. The Director of Patient Services shall document the outcome of these contacts and actions taken to address patients' expressed needs. Plan to Identify Other Potentially Affected Patients The Director of Patient Services and four Registered Nurses will conduct a 100% review of cases to identify those patients that have been discharged from Americare Inc. within the last seven months. Utilizing the Discharge Summary Form **(attachment 5)**, each nurse shall identify remaining needs and request for assistance. Each nurse shall document findings and actions taken to address the patient's expressed needs on the form. Measures and Systems The Director of Patient Services shall meet with the Registered Nurses and the Coordinators to: 1. Train and in-service staff on discharge planning requirements. **(see attachment #6).** 2. The Director of Patient Services shall emphasize staff's role as referral sources for patient and family i obtaining follow-up support services. 3. Identified problems through the discharge planning process shall be referred to the Quality Management Department. 4. Train and in-service staff on the proper documentation and utilization of the Discharge Summary Form. 5. Reinforcement of departmental standards and requirements will be discussed.	8/16/2010 8/30/2010 8/18/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
H 722	Continued From page 3 2) Patient #5 has a start of care date of "2/12/10" and discharge date "6/30/10". There is no documented evidence of a discharge summary and notification to the patient's authorized practitioner. On July 15, 2010 at 1:00 pm., the agency Director of Patient Services (DPS) was Interviewed and stated: ".... No we don't have it (discharge summary). We have to start doing it." The DPS further stated: "No, we don't do it for our private paying patients (notifying the authorized practitioner of a patient's discharge."	H 722		
H 1006	766.9(c) Governing authority Section 766.9 Governing authority. The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: (c) ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to develop a complete Emergency Disaster Preparedness Plan. Failure to have a complete Emergency Disaster Preparedness Plan places patients at risk for unsafe care during an emergency situation.	H 1006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
H 1006	Continued From page 4 The findings are: The agency: "Emergency Preparedness" and "Emergency Disaster Plan" policies lack documented evidence of the following: 1) Procedures for maintaining a current agency call down list of agency staff. 2) Procedures for maintaining a current contact list of community partners. 3) Procedures for how the agency will respond to requests for information by community partners in an emergency. 4) Procedures for orientation of staff. On July 15, 2010 at 3:30 p.m., the agency Director of Quality Management was interviewed and did not provide an explanation.	H 1006	Americare Inc.'s Emergency Preparedness Plan was revised in response to the findings of the survey that took place on July 15, 2010 to include the following: 1. Procedures for maintaining a current agency call down list. 2. Procedures for maintaining a current contact list of community partners. 3. Procedures for how the agency will respond to requests for information by community partners in an emergency. 4. Procedures for orientation of staff. Staff will be in-serviced on the amended Emergency Preparedness Plan annually. The first In-service will be completed by 8/30/2010 Copies of the Plan will be distributed to staff at the time of the in-service. New employees will be oriented to the agency's Emergency Preparedness Plan by their respective Supervisors. **(attachment # 7)**	7/20/2010 8/16/2010 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
R 722	402.6(d) Criminal History Record Check Process Section 402.6 Criminal History Record Check Process. (d) A provider may temporarily approve a prospective employee while the results of the criminal history record check are pending. The provider shall implement the supervision requirements identified in section 402.4 of this Part, applicable to the provider, during the period of temporary employment. This Regulation is not met as evidenced by : Based on record review and interview, the agency failed to provide in-home supervision during the first week of temporary employment for employees undergoing a Criminal History Record Check (CHRC). This was evident for one (1) of four (4) Home Health Aide personnel records reviewed (Employee #2). Failure to provide in-home supervision during the first week of temporary employment while awaiting the CHRC results places patients at risk for unsafe care. The finding is: Employee #2 is a Home Health Aide hired by agency on "4/10/09". The agency "Employee Work Schedule" documents Employee #2 first day worked was "4/14/09" and also worked on "6/3/09, 6/5/09, 6/8/09, 6/9/09, 6/10/09, 6/11/09, 6/12/09, 6/15/09 and 6/16/09." There is no documented evidence of in-home supervision during the first week of temporary Employment until "6/16/09".	R 722	Plan for Allegedly Affected Personnel Review of the employee's personnel record was conducted. The review revealed satisfactory annual performance evaluation. A field staff will be assigned to check on the aide utilizing the field visit indicator **(see attachment #8).** Plan to Identify Potentially Affected Personnel The Administrator will convene a meeting with staff to review the statement of deficiencies related to the supervision of the home health aides awaiting results of the Criminal History Record Check. Dedicated staff will be assigned to check the agency's CHRC database weekly to keep current with those employees due for initial visit or telephone contact. Measures and Systems The Director of Quality Management will hold weekly meetings with the clerical staff whose responsibilities are to monitor and assign supervisory visits for the paraprofessionals awaiting results of the CHRC. The purposes of this meeting will include but not be limited to: 1. Obtain updates on the number of paraprofessionals who require supervisory visits. 2. Identify those RN and Field staff available to perform the supervisory visits 3. Plan /schedule the supervisory visits Monitoring of Systems The Director of Quality Management will review the computer printout of weekly visits that have been performed as well as the number of visits that have been conducted. Report will be provided to the Administrator of Americare Inc.	8/9/2010 8/9/2010 8/9/2010 and on-going 8/9/2010 and on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
R 722	Continued From page 1 On July 15, 2010 at 4:30 pm, the agency Administrator and Director of Patient Services were interviewed and did not provide an explanation.	R 722		
R 1034	402.9(d) Responsibilities of Providers; Required Notif Section 402.9 Responsibilities of Providers; Required Notifications. (d) Policies and procedures. Each provider subject to the provisions of this Part shall have policies and procedures designed to implement the personnel policies and procedures to reflect these new requirements is sufficient compliance with this subdivision. This Regulation is not met as evidenced by: Based on record review and interview, the agency failed to revise Criminal History Record Check (CHRC) policies and procedures. This was evident for the agency Policy and Procedure Manual. Failure to revise Criminal History Record Check policies and procedures fails to ensure agency employees are implementing the CHRC according to regulations, which can result in poor patient care. The findings are: The agency: "Criminal History Record Check Policies and Procedures" lacks documented Evidence of the following: 1) All required responsibilities of providers and	R 1034	Americare Inc.'s endeavors to comply with the New York State Department of Health's Criminal History Record Check. It has always been the practice of Americare Inc. not to charge potential employees for obtaining fingerprints for criminal history record check. It is Americare Inc.'s current practice to act upon CHRC information in a timely manner. At the time of the surveillance visit, the surveyor found evidence of compliance with the requirements. Americare Inc.'s CHRC policy and procedure was amended to reflect our on-going implementation of the New York State Department of Health CHRC requirements. **(See attachment 9)**	7/15/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LC 0423B	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE OF NEW YORK CITY	**3044 CONEY ISLAND AVENUE BROOKLYN, NY 11235**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFECIENCIES (EACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFECIENCY)	(X5) COMPLETE DATE
R 1034	Continued From page 2 required notifications (402.9); 2) Prohibiting the charging of employees for a criminal history record check; 3) Requesting, receiving, reviewing and acting upon CHRC information in a timely manner (402.4)(a)(1). On July 15, 2010 at 3:30 p.m., the agency Director of Quality Management was interviewed and did not provide an explanation.	R 1034		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SEGNATURE TITLE Nancy Hahn (X6) DATE 8/6/2010